Dental Hygiene Clinic
31 College Drive
Concord, New Hampshire 03301
Phone: (603)230-4023 Fax: (603)230-9305
Email Address: NHTIDentalClinic@ccsnh.edu

CHILD PERMISSION SLIP FOR CARE
TO BE TREATED AT NHTI's DENTAL HYGIENE CLINIC (Age 17 and under)

Child's Name: _________________________ Address: ____
Street City/Town State Zip Code

Father's Name ____

Father's Home Ph: __________________________ (w) _________________________ (cell) ________________________

Mother's Name: ____

Mother's Home Ph: _________________________ (w) _________________________ (cell) ________________________

BRIEF CASE HISTORY

Child's Date of Birth: ________________

Dentist's Name: ________________________ Address: ____
Street City/Town State Zip Code

Phone Number: _____________________________

Physician's Name: _________________________ Address: ____
Street City/Town State Zip Code

Phone Number: _____________________________

Date of Last Teeth Cleaning: _________________ Date of Last Fluoride Treatment: _______________

Date of Last Dental Exam with Dentist: _____________________Date of Last Dental X-rays: __________________

Date of Last Medical Examination: ____

FOR YOUR CHILD TO BE PROVIDED NHTI DENTAL HEALTH SERVICES THIS PERMISSION FORM MUST BE COMPLETED, SIGNED AND RETURNED TO NHTI DENTAL HYGIENE CLINIC.

(Please circle either Yes or No)

1. Is your child under the care of a physician? YES NO
   If so explain: ____
2. Has your child had any serious illness or operation? YES NO
   If so explain: ____
3. Does your child have or has the child had any of the following diseases or problems:
   A. Rheumatic fever or Rheumatic Heart Disease YES NO
   B. Congenital Heart Disease YES NO
   C. Heart Murmur, if so Type: YES NO
   D. Congenital Heart Disease YES NO
   E. Pacemaker YES NO
   F. Sub-Acute Bacterial Endocarditis YES NO
   G. Cardiovascular Disease (heart trouble, heart attack, stroke, coronary insufficiency, high blood pressure) YES NO
   H. Prosthetic Joint Replacement YES NO

I. Kidney Trouble/Disease YES NO
J. Allergy YES NO
K. Asthma or Hay fever YES NO
L. Epilepsy YES NO
M. Fainting spells/ Seizures YES NO
N. Diabetes YES NO
O. Hepatitis, Jaundice or Liver Disease YES NO
P. Venereal Disease YES NO
Q. Tuberculosis YES NO
R. Lung disease or Condition YES NO
S. Cancer, YES NO
If so explain: ____
T. Low Blood Pressure YES NO
U. Glandular Disease YES NO
V. Pregnant YES NO
W. Blood Disorders, Anemia YES NO
X. Other YES NO

4. Is your child taking any drug or medication? YES NO
If so explain: ____

5. Is your child allergic or react adversely to:
A. Local anesthetics YES NO
B. Penicillin or other antibiotics YES NO
C. Sulfa Drugs YES NO
D. Barbiturates, sedatives YES NO
E. Aspirin YES NO
F. Iodine YES NO
G. Codeine or other narcotics YES NO
H. Other YES NO

Additional Information:

If you answered "YES" to any of the above questions, please explain:

____

____

Does your child require any pre-medication before dental treatment? YES NO
If yes, please explain: ____

Are any special instructions necessary?

____

____

I, ____, authorize an examination, cleaning,
Printed Name
sealants, radiographs, and fluoride treatment for my child at the NHTI Dental Hygiene Clinic.

____ ____________________
Parent or Legal Guardian Signature Date