QUEENSCARE

MOBILE DENTAL PROGRAM
PERMISSION FORM

For your child to participate in the QueensCare/USC Mobile Dental Program, please complete and sign this form as well as the attached yellow medical history form and return them to your child's teacher. **Use black or blue ink.**

With your signed permission, your child will then have a dental exam, including dental X-rays. You will be notified of our findings after the examination and x-rays. If your child needs additional treatment a separate form titled "Program Treatment Authorization" (orange form) will be sent home. Please sign the orange form and return to your child's teacher. The signed form must be given to your child's teacher before treatment begins.

WE WILL NOT BILL YOUR INSURANCE

_____ Yes, I want my child to participate in the QueensCare and USC Mobile Dental Program. (If you choose this option, the pink Permission Form & the yellow Medical Form must be attached.)

_____ No, I do not want my child to participate in the QueensCare and USC Mobile Dental Program. (Return to your child's teacher). **Parent Signature** _____

Child's Name _____

Grade _____ Room #_____ Teacher's name _____

School Name _____ School Address _____

Daytime Phone #_____ Emergency # _____

Cell Phone # _____Child's Date of Birth _____ Age _____

Gender (circle one): Male ☐ Female ☐ Other ☐

Ethnicity/Race: Latino ☐ African American ☐ White ☐ Asian ☐ Pacific Islander ☐ Other ☐

Has your child been to the dentist in the past 6 months? Yes ☐ No ☐

I, the undersigned parent or guardian of the above named child, do hereby give my permission for QueensCare/USC Mobile Dental Program to examine and treat my child. I also authorize LAUSD to provide to QueensCare/USC Mobile Dental Program health services information from my child's education/medical record. Requested information shall be limited to health services documentation. We will contact you by phone using the phone numbers above, if this is a problem let us know.

Parent/Legal Guardian Name

Print _____

Signature _____ Date _____

Please return this form to your child's school as soon as possible.
QC1 323-552-3458, QC2 323-552-6875

PEDIATRIC DENTISTRY | MEDICAL HISTORY FORM

Child's Name:_____ Date of Birth: _____ Gender:_____ Today's Date:_____
Address: _____ Chart Number: _____
Child's legal guardian(s): _____ Telephone: _____ Relationship to Child: _____
Physician's name (Primary Medical Doctor): _____ Telephone: _____

Please circle the appropriate answer and answer all questions.

Medical History

1. Does your child have any medical condition(s) that requires regular doctor visits?..... YES NO
   a. If yes, for what reason?_____
2. Does your child see any other medical specialists?.....YES NO
   a. If yes, please list: _____
3. Date of last physical exam (with medical doctor):_____
   a. Is your child up to date on immunizations?.....YES NO
4. Was your child premature?.....YES NO
   a. If yes, how many weeks? _____
   b. Any complications with birth? _____
5. Has your child had any hospitalizations or emergency room visits?.....YES NO
   a. If yes, when and why? _____
6. Has your child had a serious illness or surgery?.....YES NO
   a. If yes, when and what was it?_____
7. Does your child have (or ever had) any of the following diseases?
   a. Rheumatic fever or rheumatic heart disease……..YES NO
   b. Congenital heart disease or heart murmur……YES NO
   c. Allergy?
      i. Seasonal allergies……YES NO
      ii. Food……..YES NO
         a. What kind? _____
      iii. Latex……YES NO
      iv. Local anesthetics……..YES NO
      v. Penicillin or other antibiotics……...YES NO
      vi. Sulfa drugs……YES NO
      vii. Barbiturates, sedatives, or sleeping pills……...YES NO
      viii. Aspirin……...YES NO
      ix. Ibuprofen, morphine, codeine, acetaminophen, meperidine……YES NO
      x. Other:_____
   d. Asthma……YES NO
   e. Lung problems, frequent coughs or history of pneumonia.....…… YES NO
   f. Hives or skin rash……YES NO
   g. Fainting spells……YES NO
   h. Hepatitis, jaundice or liver disease……...YES NO
   i. Diabetes, hypoglycemia or hyperglycemia……..YES NO
   j. Inflammatory rheumatism (painful or swollen joints)……YES NO
   k. Snoring……YES NO
   l. Sleep apnea……...YES NO
   m. Reflux or gastrointestinal disease……YES NO
   n. Kidney trouble/bladder trouble……YES NO
   o. Tuberculosis (TB)/persistent cough or cough up blood……...YES NO
   p. Epilepsy or seizures……..YES NO
   q. Sickle cell disease or trait……YES NO
   r. Thyroid disease/pituitary problems……..YES NO
   s. Autism/Autism Spectrum Disorder……..YES NO
   t. Attention deficit/hyperactivity disorder (ADD/ADHD)……..YES NO
   u. Developmental disorders, learning problems/delays, or intellectual disability……YES NO
   v. Hemophilia/bleeding disorders……YES NO
   w. Hearing impairment……YES NO
   x. Vision impairment……YES NO
   y. Behavioral, emotional, communication, or psychiatric problems/treatment……YES NO
   z. Cleft lip/palate……..YES NO
   aa. Cerebral palsy……...YES NO
   bb. Presence of a shunt……...YES NO
   cc. AIDS/HIV ……YES NO
   dd. Venereal disease/sexually transmitted infection (STI)……YES NO
   ee. Other:_____
8. Has your child ever had general anesthesia or sedation before?.....YES NO
   a. If yes, any complications?_____
   b. Any family members with any complications?.....YES NO
9. Is your child taking medication now?.....YES NO
   a. If yes, are they taking any of the following?
      i. Antibiotics or sulfa drugs……YES NO
      ii. Anticoagulants (blood thinners)…….. YES NO
      iii. Asthma medications……YES NO
      iv. Medicine for high blood pressure……YES NO
      v. Cortisone or steroids……YES NO
      vi. Tranquilizers……YES NO
      vii. Aspirin or any pain medications……..YES NO
      viii. Dilantin or other anticonvulsant……..YES NO
      ix. Insulin, Tolbutamide, Orinase, or similar drug……YES NO
      x. Vitamin or herbal supplements……YES NO
      xi. Any other?_____
10. Has your child had abnormal bleeding associated with previous surgery, extractions or accidents?.....YES NO
11. Does your child bruise easily?.....YES NO
12. Has your child ever had an organ transplant or bone marrow transplant?.....YES NO
13. Has your child ever required a blood transfusion?.....YES NO
14. Does your child have any blood disorders such as anemia, etc.?.....YES NO
15. Has your child ever had surgery, x-ray, or chemotherapy for a tumor, growth, or cancer?.....YES NO

Dental History

16. Does your child have a disability that prevents treatment in a dental office?.....YES NO
17. Has your child had any serious trouble associated with previous dental treatment?.....YES NO
18. Date of last dental examination: _____
19. Does your child have a history of any of the following?
   a. Mouth sores or fever blisters……YES NO
   b. Inherited dental problems or characteristics……YES NO
   c. Bad breath……YES NO
   d. Bleeding gums……...YES NO
   e. Toothache/Cavities……..……YES NO
   f. Injury to teeth, mouth or jaws……..YES NO
   g. Clenching/grinding teeth……...YES NO
   h. Crooked teeth……...YES NO
   i. Excessive gagging……YES NO
   j. Oral habits (chewing fingernails, clenching/grinding teeth, etc.)…YES NO
20. Is there a family history of cavities?.....YES NO

Adolescent Patient (for patients 11 years and older)

21. Does your child have any history of:
   a. Tobacco use (cigarettes, e-cigarettes, etc.)……...YES NO
   b. Oral piercings/jewelry……...YES NO
   c. Alcohol or recreational drug use/prescription abuse……YES NO
   d. Consumption of sports drinks (Gatorade, Powerade etc.)……YES NO
   e. Anxiety/depression……...YES NO
22. Does your child participate in sports or high-speed activities (skiing, skateboarding, etc.)?.....YES NO
23. Has your child been immunized against human papilloma virus (HPV)?.....YES NO
24. Is your child pregnant now or does she think she may be?.....YES NO N/A
25. Does your child anticipate becoming pregnant?.....YES NO N/A
26. Is your child taking contraception? ……..……...YES NO N/A

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/her medicines change, I will inform the doctor at the next appointment without fail. I certify that I am the legal guardian of the child named above.

Legal Guardian's Name: _____Legal Guardian's Signature: _____ Date: _____

MEDICAL HISTORY/PHYSICAL EXAM REVIEW (FOR STAFF USE ONLY)

DATE	ADDITION	STUDENT SIGNATURE	FACULTY SIGNATURE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____