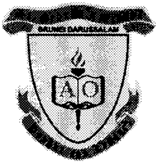


سكوله سينت جورج
ST. GEORGE'S SCHOOL
No. 11, Jalan Kumbang Pasang, BA1512. P.O. Box 2201, Bandar Seri Begawan BS8674, Negara Brunei Darussalam
Tel.: (673) 2224458 / 2228449 Fax: (673) 2226910 E-mail: stgeorge@brunet.bn Website: www.stgeorges.edu.bn

NOTICE

Our Ref: SGS/SC/P/692

Date: 5th May, 2015

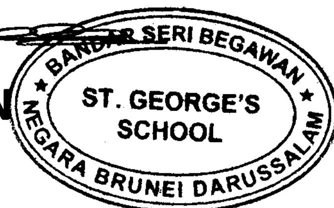
To: Parents/Guardians concerned

CONSENT FORM FOR DENTAL TREATMENT

Please fill in the consent form as requested by the Department of Dental Services, Ministry of Health.

Kindly return the consent form to your child/children's respective class teacher by Saturday, 9th May 2015.

Your cooperation is highly appreciated.



JANIDI JINGAN
Principal

DEPARTMENT OF DENTAL SERVICES
MINISTRY OF HEALTH
BRUNEI DARUSSALAM

CONSENT FORM FOR DENTAL TREATMENT

NAME : ....

D.O.B : .... I.C. NO. (if any) : ....

SEX : .... RACE : ....

SCHOOL : .... YEAR : ....

MOTHER / GUARDIAN NAME : .... TEL. NO. : ....

OCCUPATION : .... I.C. NO. : ....

FATHER / GUARDIAN NAME : .... TEL. NO. : ....

OCCUPATION : .... I.C. NO. : ....

ADDRESS : ....

Types of treatment **as** is considered necessary by Dental Officer / Dental Nurse :-

a. Dental Checkup
b. Prophylaxis (Cleaning)
c. Fillings
d. Fissure Sealant
e. Fluoride Varnish
f. Extractions
g. Referral (if any)

* Please tick ☑ as appropriate

I

Consent ☐ my child to receive dental treatments.

Do Not Consent ☐ please kindly explain why : ....

Signature : .... Date : ....

Name : (..)

Relationship with child : ....

* Please turn to the next page.

* Please tick ✓ as appropriate

	YES	NO
1. Has your child suffered from any serious illness or undergo any operation?	☐	☐

If so, state the year : .... illness : ....

Treatment : ....

2. Has your child taken any drug / medication regularly? If so, state name and form of medication :	☐	☐

....

3. Is your child suffering from :	YES	NO
a. Diabetes?	☐	☐
b. Nephrotic Syndrome ?	☐	☐
c. Hypertension?	☐	☐
d. Heart Disease / Problem ?	☐	☐
e. Asthma / Breathless ?	☐	☐
f. Tuberculosis (T.B.) ?	☐	☐
g. Fits, Convulsions, Epilepsy ?	☐	☐
h. Fainting Spells ?	☐	☐
i. Urinary Problem ?	☐	☐
j. Hepatitis or other Liver Disease?	☐	☐
k. Blood Disorders / Anaemia / Haemophilia / Thalassaemia / Leukemia)	☐	☐
l. Allergy to any Drug /Food (please specify) ?	☐	☐
m. Metabolic Disorders (G6PD)	☐	☐
4. Any Problem in mental / physical development (retardation)?	☐	☐
5. Is there any problem with limb / hearing / eyesight?	☐	☐
6. Has the child been seen before in any Dental Clinic?... if yes, please specify treatment carried out :	☐	☐

7. Any other Health problem (please specify) ? ....

....