

GIVE KIDS A SMILE!
Health and History Form

First _____ MI _____ Last _____

Date of Birth _____ Sex _____ Phone # _____ Emergency # _____

Address: _____
Street City Zip

Does your child have or has your child ever had:

Asthma	Y	N	Congenital heart disease	Y	N
Heart Murmur	Y	N	Rheumatic heart disease	Y	N
Diabetes	Y	N	Bleeding problems	Y	N
Seizures	Y	N	Hepatitis	Y	N
HIV/AIDS	Y	N	Tuberculosis	Y	N
Cancer	Y	N	Kidney Disease/Dialysis	Y	N
Prosthetic limb	Y	N	Joint replacement	Y	N
Reaction to anesthetic	Y	N	Other diseases	Y	N
Blood transfusion	Y	N	What other diseases? _____		

Is your child taking any medications? Y N List: _____

Does your child have allergies? Y N What allergies? _____

Has your child had any other serious illness or operation? Y N
If yes, What? _____

Is there anything else we should know about the health of your child?
List _____

Who should we contact on the day of service to determine your child's care?

Name(print) _____ Phone _____

I give consent for my child to participate in the Give Kids a Smile project conducted by the Florida Dental Association, Florida Department of Children and Families, and Florida Department of Health. To the best of my knowledge, the medical history questions have been answered correctly and accurately. I allow my child to receive local anesthetic (numbing of the teeth).

Name of Parent/Guardian (printed) _____

Signature _____ Date _____