

SCHOOL HEALTH SERVICE PARENT QUESTIONNAIRE

In order to update your child's school health record, please complete this questionnaire. If you need help completing the form, please contact the School Nurse.

1. Name of Child:

Sex: Male Female Date of Birth: NHS No:

Ethnicity: Religion.....

Language: Interpreter required: YES / NO

Home Address:

..... Post Code:

Telephone No: Home:

Parent/Carer Work: Mobile:

2. SCHOOLS

Current School: Class:

Previous School:

3. Are there any other children living at home? Yes No

4. Name and address of GP:

..... Tel No

5. Do you give consent for the School Nurse to contact your GP if your child has a health condition and takes regular medication? Yes No

6. Does your child regularly attend the GP or a hospital for any treatment Yes No

(If yes, please give details).....

.....

Name of Hospital / Clinic attending:

Name of Consultant: Hospital No:

Please provide any recent copies of hospital/clinic letters you have received from your GP or Hospital.

7. Does your child take regular medicine? Yes No

(If yes, please give details):



8. Does your child suffer from any of the following medical conditions?

- Allergies? Yes No
- Asthma? Yes No

(If yes, please give details):

9. Does your child attend a dentist? Yes No

10. Has your child visited the dentist in the last year? Yes No

11. Is your home smoke free? Yes No

12. Would you like further information from the school nurse to help you protect your child from the harmful effects of smoking? Yes No

13. Do you have any concerns about your child's health or behaviour?

	Yes	No	Not Sure	Comment
Eyesight				
Hearing				
Speech				
Behaviour				
Bed-wetting or day time wetting				
Balance problems or clumsiness				
Other concern				

14. Does your child have a physical disability? If yes, please give details

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15. Does your child have a learning difficulty? If yes, please give details.

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16. **Please detail all immunisations that your child has been given using the enclosed form.**

Signed: (Parent/Carer)

PRINT NAME:

Date:



**UK ROUTINE CHILDHOOD
IMMUNISATION PROGRAMME**

Please complete the table stating the dates your child received the immunisation. **THESE CAN BE FOUND IN YOUR CHILD'S RED BOOK.**

When to immunise	Diseases protected against	Date of Vaccine	Refused Vaccine
AT BIRTH	Tuberculoucis		
2 MONTHS OLD	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib)		
	Pneumococcal infection (PCV)		
	Rotavirus		
3 MONTHS OLD	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib)		
	Meningitis C (Meningococcal Group C)		
	Rotavirus		
4 MONTHS OLD	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib)		
	Meningitis C (Meningococcal Group C)		
	Pneumococcal Infection (PCV)		
12-13 MONTHS OLD	Hib/Men C Booster		
	Pneumococcal Infection Booster (PCV)		
	Measles, mumps and rubella (MMR)		
PRE SCHOOL BOOSTER GIVEN AT 3 YEARS & 4 MONTHS OR SOON AFTER	Diphtheria, tetanus, pertussis and polio		
	Measles, mumps and rubella (MMR)		

Please return the completed questionnaire to the School Nurse via the School Secretary in the envelope provided as soon as possible.

This information will be kept safely in your child's School Health Record.

