**SCHOOL HEALTH QUESTIONNAIRE – CONFIDENTIAL 2020**

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| **CHILD DETAILS**  Surname:  First Name:    Address:  Postcode:    Date of Birth:  NHS Number:  (may be found in red Child Health Book)    Boy/Girl :  (Delete as appropriate)  Ethnicity:  GP Surgery: | **PARENT/CARER DETAILS**  Surname:  First Name:  Address:  Postcode:  Relationship to child:  Contact numbers:  Email address:  Do you consent to being sent health promotion material via email: Yes/No  Date form completed: |
| **PLEASE NOW COMPLETE THE HEALTH QUESTIONS FOR YOUR CHILD OVERLEAF** | |
| **CONTACT US**  The Public Health Nursing Team are here to support you and your child. If you would like further advice or information, please visit our website or contact us: | |

<https://www.publichealthnursing4slough.co.uk/school-nursing/your-school-nursing-service/>

**🕿 01753 373464**

**🖰 publichealthnursing.4slough@nhs.net**

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| **PRIVATE & CONFIDENTIAL – SCHOOL HEALTH QUESTIONNAIRE YEAR RECEPTION** | | | | |
| **Child’s Name** | | **Please tick** | | **School**  **Class** |
| **Yes** | **No** |
| **Please use the box below to add any comments or tell us what you would like to discuss.** |
| **\*\*\*** | **Would you like the school nurse to contact you for any identified health needs?** |  |  |  |
| 1 | Are you concerned about your child’s bedtime routine or quality of sleep? |  |  |  |
| 2 | Do you have any concerns about your child’s emotional wellbeing or behaviour? |  |  |  |
| 3a | Are you concerned about your child’s hearing? |  |  |  |
| 3b | Is your child currently under the care of Audiology services or the Ear Nose & Throat Department? |  |  |  |
| 3c | Does your child use a hearing aid? |  |  |  |
| 4 | Are you concerned about your child’s vision? |  |  |  |
| 4a | Is your child currently under the care of an Orthoptist? |  |  |  |
| 4b | Does your child see an Optician? |  |  |  |
| 4c | Does your child wear glasses? |  |  |  |
| 5 | Does your child have an Educational Healthcare Plan in place? |  |  |  |
| 6 | Do you have any concerns with regards to your child’s growth and development? |  |  |  |
| 7 | Has your child been referred to a Dietician? |  |  |  |
| 8 | Does your child have any genetic conditions? |  |  |  |
| 9a | Does your child have problems with Night time wetting? |  |  |  |
| 9b | Does your child have problems with  Daytime wetting? |  |  |  |
| 9c | Does your child have problems with Soiling? |  |  |  |
| 10 | Does your child have any long-term medical conditions? |  |  |  |
| 11 | Is your child under the care of a Hospital Consultant or any other Health Professional? |  |  |  |
| 12 | Is your child taking any long-term prescribed medication? |  |  |  |
| 13 | Has your child suffered a severe allergic reaction that requires medication in school? |  |  |  |
| 14a | Is your child registered with a dentist? |  |  |  |
| 14b | Has your child had a dentist check-up in the last 12 months? |  |  |  |
| 15 | Is your child up to date with all of their immunisations? |  |  | If unsure please contact your GP |
| 16 | Does your child take part in at least 30 minutes of physical activity every day? |  |  |  |
| 17 | Are there any other physical or mental health concerns within the family household that you would like support with? |  |  |  |