NHS

Trafford Local Care Organisation

Leading local care, improving you

PRIMARY SCHOOL HEALTH QUESTIONNAIRE FORM

Confidential – please return to your school nurse or save a copy and email to school.healthadmin@mft.nhs.uk

Child Details (IN CAPITAL)

NAME OF CHILD ____

Gender: Male ☐ Female ☐

Date of Birth ______________________ Place of Birth ______________________

NHS Number ____

Home Address____

Any Previous Addresses ____

Telephone: Home ______________Mobile ______________Work__________

Parent's email address ____

Name of School ____

Any previous school and address ____

Name and address of General Practitioner (family doctor) ______________________________

____

1. Are your child's immunisations up to date? (Including 2 doses of MMR) –Yes ☐ No ☐ Unsure ☐
   If you are new to the area - ***Please attach a copy of your Child's immunisations***

2. Is your child registered with a dentist? YES ☐ NO ☐

3. **Does your child have any of the following? (Please give details)**

	YES	NO	Please give details
Disability			
Asthma requiring current treatment			
Epilepsy (Fits/ convulsions)			
Diabetes			
Allergies			
Other medical problems (please specify)			

4. **Is your child on any medication/ inhalers, which might have to be given in school?** Yes ☐ No ☐
   If yes please give details
   ____
   ____

SEE OVERLEAF

6. Please indicate below if you have any concerns or if your child is receiving any treatment regarding the following.

	YES	NO	Please give details
Hearing			
Vision			
Height/Weight			
Behaviour			

7. How would you describe the ethnicity of your child? (Please circle as appropriate)

White
A. British
B. Irish
C. Any other white background

Mixed
D. White and Black Caribbean
E. White and Black African
F. White and Asian
G. Any other mixed background

Asian or Asian British
H. Indian
J. Pakistani
K. Bangladeshi
L. Any other Asian background

Black or Black British
M. Caribbean
N. African
P. Any other Black background

Other Ethnic Groups
R Chinese
S Any other Ethnic group

Language spoken at home ____

Please do not hesitate to contact the School Nurse if your child has any health, cultural or religious needs that you wish to discuss.

Signed____________________________________ Date_________________________

Please print name of parent/guardian ____

Relationship to child __________________________Parental responsibility YES/ NO (please circle)

Thank you for completing this form. Please return to school for the attention of the School Nurse. Please inform the School Nurse if at any time any of the above information changes so that records can be updated.

FOR OFFICE USE ONLY
Questionnaire screened Yes / No   Action needed Yes / No
Outcome____
____
____

Name/Designation ____

Signature ___________________________ Date______________________________________