

PRIMARY SCHOOL HEALTH QUESTIONNAIRE FORM

**Confidential – Please return to your school or save a copy and email to the email address:
school.healthadmin@mft.nhs.uk**

1. 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) _____

2. Are your child's immunisations up to date? (Including 2 doses of MMR) –Yes No Unsure

3. Is your child registered with a dentist? YES NO

4. 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)			

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

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

Asian or Asian British

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

Other Ethnic Groups

- R Chinese
- S Any other Ethnic group

Mixed

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

Black or Black British

- M. Caribbean
- N. African
- P. Any other Black background

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 _____	