PRIMARY SCHOOL HEALTH RECORD

VISION

- Do you have any concerns about your child's vision? Yes ☐ No ☐
  *(If yes, please indicate)*_____
- Has your child had any of the following? *(Mark all that apply)*
  Poor sight ☐ Squint/turned eye ☐ Eye injury ☐ Operation on eyes ☐
- Has your child been prescribed with glasses? Yes ☐ No ☐
  *(If yes, when should they be worn?)*_____
- Has your child received or are they receiving medical care for his/her eyes/vision? Yes ☐ No ☐
  *(If yes, please describe)*_____Date of last appointment (month/year)___/___

HEARING

- Do you have any concerns about your child's hearing? Yes ☐ No ☐
  *(If yes, please indicate)*_____
- Has your child had any of the following? *(Mark all that apply)*
  Repeated ear infections ☐ Discharging ears ☐ Hearing loss ☐ Grommets ☐
  Other ear operation_____
- Has your child received or are they receiving medical care for his/her ears/hearing? Yes ☐ No ☐
  *(If yes, please describe)*_____Date of last appointment (month/year)___/___

If you wish to discuss any of these health concerns, please contact the Community Health Nurse at your child's school.

Progress Notes

Office use only:

Child's name:_____ DOB:___ /___ /_____

Date, time and location	Comment	Name, signature and designation

CONFIDENTIAL RECORD

HP3168 NOV'09 24257

Department of Health
GOVERNMENT OF WESTERN AUSTRALIA

*Child's name:*_____ *Class:*_____ *Calendar year:*_____

*MRN:*_____ *Retain until:*_____

School Entry Health Assessment

Dear Parent/Guardian

The School Health Service is pleased to offer health assessments for your child. With your permission, the following will be carried out by a Community Health Nurse at your child's school:

- **Vision assessment** (This includes testing your child's distance vision and using a small light to look into the eye and watching the movements of the eye);
- **Hearing assessment** (This includes testing your child's hearing and looking into the ear canal);
- **General developmental health assessment** (This is a brief assessment of any health related concerns based on the information provided by you on this questionnaire or concerns noted by the teacher or nurse).

The Community Health Nurse will contact you if any further action is needed. This may include a follow-up assessment, or a referral to other services if needed.

A copy of the assessment results will be returned to you to keep with your child's Personal Health Record. A copy of the results will be kept with your child's academic record at the school and may be accessed by school staff if needed. Another copy will be kept by the Community Health Nurse.

You are welcome to contact the Community Health Nurse at your child's school to discuss this health assessment or any concerns about your child's health at any time during their school years.

If you agree to your child being assessed by the Community Health Nurse, please complete the inside of this form and sign below. Please return it to your child's school as soon as possible.

We hope your child has a happy and healthy time at school. Thank you for your cooperation.

IMPORTANT

I have read and understand the above letter and consent to:

- A health assessment of my child by the Community Health Nurse as described above; and
- A copy of the assessment results being kept with my child's academic record; and
- Sharing of information about my child between the Community Health Nurse and relevant school staff where it helps in the management of my child's learning, health or wellbeing.

Signature of parent or guardian:_____ Date___ / ___ / 20___

Name:_____ Relationship to child:_____

If you would like help completing this form, please contact the Community Health Nurse at your child's school.

(Please tick if you would you like a copy of this letter translated into Chinese/Arabic/Vietnamese)

如果你想看本函的中文译本，请在方框上打钩。 ☐ *(Chinese)*

اذا كنت ترغب في الحصول على نسخة من هذه الرسالة باللغة العربية، يرجى وضع علامة في ☐ *(Arabic)*

Xin vui lòng đánh dấu vào ô vuông nếu bạn cần lá thư này bằng tiếng Việt ☐ *(Vietnamese)*

Please complete details inside

PARTICULARS OF CHILD

Boy ☐ Girl ☐

School:_____

Family name:_____

Given name(s):_____ Preferred name:_____

Address:_____

_____ Postcode:_____

Child's date of birth___ /___ /_____ Weight at birth:_____

Country/state of birth:_____

Is your child of Aboriginal or Torres Strait Islander origin? Yes ☐ No ☐

Child's Medicare Number: ☐☐☐☐☐☐☐☐☐☐ Child's reference number: ☐

Child's brothers or sisters:

1. Full name:_____ Year of birth:_____
2. Full name:_____ Year of birth:_____
3. Full name:_____ Year of birth:_____
4. Full name:_____ Year of birth:_____
5. Full name:_____ Year of birth:_____

Parent or guardian for contact

Family name:_____

Given name(s):_____

Phone No. (Home):_____ (Work):_____ (Mobile):_____

Email: _____

Mother's country of birth:_____ Father's country of birth:_____

Main language spoken at home:_____ Interpreter needed? Yes ☐ No ☐

Please indicate if there is any family history of medical, vision or hearing conditions:_____

_____

Has your child attended any of the following?

Child Health Centre? Yes ☐ No ☐ If yes, which one most recently?_____

Other School? Yes ☐ No ☐ If yes, which one most recently?_____

4 Year Old Healthy Kids Check with doctor Yes ☐ No ☐ If yes, please give details of health concerns_____

IMMUNISATION

You are reminded that it is an enrolment requirement that you provide a photocopy of your child's immunisation record to the school. Have you done this? Yes ☐ No ☐ *If no, please attach a copy with this form.*

Has your child had the 4 year old immunisation?

Yes ☐ (Date Vaccinated ____/____/____ Where Vaccinated_____) No ☐ Unsure ☐

PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)

1. Please list any concerns about your child's learning, development and behaviour.

   _____

2. Do you have any concerns about how your child talks and makes speech sounds?
   Circle one: No Yes A little COMMENTS:_____
3. Do you have any concerns about how your child understands what you say?
   Circle one: No Yes A little COMMENTS:_____
4. Do you have any concerns about how your child uses his or her hands and fingers to do things?
   Circle one: No Yes A little COMMENTS:_____
5. Do you have any concerns about how your child uses his or her arms and legs?
   Circle one: No Yes A little COMMENTS:_____
6. Do you have any concerns about how your child behaves?
   Circle one: No Yes A little COMMENTS:_____
7. Do you have any concerns about how your child gets along with others?
   Circle one: No Yes A little COMMENTS:_____
8. Do you have any concerns about how your child is learning to do things for himself/herself?
   Circle one: No Yes A little COMMENTS:_____
9. Do you have any concerns about how your child is learning preschool or school skills?
   Circle one: No Yes A little COMMENTS:_____
10. Please list any other concerns:

    _____

    _____

    _____

GENERAL HEALTH

- Does your child have any ongoing health problems or conditions? Yes ☐ No ☐
  *(If yes, please indicate)*_____
- Has this condition been attended to by a health professional? Yes ☐ No ☐
  *(If yes, please indicate)*_____
- Do you consider your child to be: Healthy weight ☐ Underweight ☐ Overweight ☐
- Does your child have a Medic Alert? Yes ☐ No ☐
  *(If yes, what is its inscription and ID number?)*_____
- Is there any other information you feel would be helpful for the Community Health Nurse (for example changes or major events in the family)?

  _____

  _____

  _____

Please continue over page