



Office use only

UMRN: _____

Retain Until: _____

Academic year	K	P	1	2
Calendar year				
Form/class				

Dear Parent/Guardian

After reading the accompanying *Information for the School Entry Health Assessment*, please **complete this form (four pages) and sign** in the box on the back page. Please return the form in the envelope provided to your child's school as soon as possible.

If you would like help completing this form, please contact the school health nurse at your child's school. Let us know if you need an interpreter.



Child details

Boy Girl

School: _____

Surname: _____ Given name: _____

Previous names known by: _____ DOB: ____/____/____

Postal address: _____

Postcode: _____ Weight at birth: _____

Country/state of birth: _____

Child's Medicare no: Child's reference no: Expiry date: ____/____/____

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

Child's brothers or sisters:

1. Full name: _____ Date of birth: ____/____/____

2. Full name: _____ Date of birth: ____/____/____

3. Full name: _____ Date of birth: ____/____/____

4. Full name: _____ Date of birth: ____/____/____

5. Full name: _____ Date of birth: ____/____/____

Parent or guardian for contact

Parent Guardian

Surname: _____ Given name: _____

DOB: ____/____/____ Email: _____

Phone no.: Mobile: _____ Home: _____ Work: _____

Who does your child usually live with? (e.g. both parents, mother only, grandparents) _____

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

Has your child attended another school previously? Yes No

If yes, name/s of previous schools: _____

General Health

Please describe any current or relevant past medical history: _____

Have you seen a health professional about this? Yes No

If yes, provide the health professional's contact details _____

Do you have any behaviour concerns about your child? Yes No

If yes, what are they? _____

Parent's assessment of child's development

Here are some things that many children can do by the time they turn 4. Tick the ones your child **can** do.

Social/Emotional

- Enjoys doing new things
- Is more and more creative with make-believe play
- Would rather play with other children than by themselves
- Talks about things of interest

Comments: _____

Language/communication

- Knows some basic rules of grammar such as correctly using 'he' and 'she'
- Sings a song or says a poem from memory
- Tells stories
- Can say first and last name

Comments: _____

Learning, thinking, problem solving

- Names some colours and some numbers
- Understands the idea of 'same' and 'different'
- Draws a person with 2 to 4 body parts
- Uses scissors
- Tells you what is going to happen next in a book

Comments: _____

Movement and physical development

- Hops and stands on one foot for up to 2 seconds
- Catches a bounced ball most of the time
- Pours drink, cuts food with supervision, and mashes own food

Comments: _____

Do you have concerns/worries about your child's speech and/or development? Yes No

Please comment _____

Is your child toilet trained? Yes, all the time Sometimes No, not yet

Please comment _____

Vision

Has anyone in your family had a childhood vision problem?

Yes No If yes, please describe _____

Has your child had a vision test with a doctor, nurse, optometrist or orthoptist? Yes No

If yes, please describe: _____ Date of test ____/____/____

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 glasses? Yes No

If yes, when should they be worn? _____

Has your child ever had medical care for eyes/eyesight? Yes No

If yes, please describe: _____ Date of last appointment (month/year) _____

Do you have any other concerns/worries about your child's eyes or eyesight? Yes No

If yes, please describe _____

Hearing

Has anyone in your family had childhood hearing problems? Yes No

If yes, please describe _____

Has your child had any of the following? (mark all that apply)

Repeated ear infections Discharge in ears Hearing loss Grommets

Other ear operation Please describe _____

Has your child ever had medical care for ears/hearing? Yes No

If yes, please describe _____

Date of last appointment (month/year) _____

Do you have any other concerns/worries about your child's hearing and/or ears? Yes No

If yes, please describe _____

Growth

Do you think your child is: Underweight Healthy weight Overweight

The school health nurse will measure your child's height and weight and calculate his/her Body Mass Index (BMI). Your child will not be told the results. If your child is not within the healthy weight range, you will receive more information on BMI with the results, and the school health nurse will contact you to offer information and support.

Teeth

Do you have concerns about your child's teeth? Yes No

If yes, please describe _____

Has your child had a dental check? Yes No Date: ____/____/____

Other Information

In the past twelve months, has your child been affected by any of the following events (e.g. divorce/separation of parents, death of a relative or friend, remarriage of parent(s), serious illness of parent(s) (including mental illness), serious illness of sibling(s) (including Autism/ADHD), parent's change of job, parent's loss of job/financial pressures, move to a new house, new baby in the house, child witnessing violence, moved to out of home care)?

Is there any other information you feel would be helpful for the school health nurse?

Immunisation

Australian Immunisation Register (AIR)

To enrol in school, you must provide a current copy of your child's immunisation history statement to the school.

You can access this information using your Medicare online account through myGov (my.gov.au) or by emailing air@humanservices.gov.au

Your child should have the 4 year old immunisation as soon as they turn 4.

Sign here

I have read and understand the *Information for the School Entry Health Assessment* and consent to:

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

Name (parent or guardian): _____

Relationship to child: _____

Signature (parent or guardian): _____ Date: ____/____/____