Government of **Western Australia**
Child and Adolescent Health Service
WA Country Health Service

School Entry Health Assessment

Office use only

UMRN: _____

Retain Until: _____

Academic year	K	P	1	2
Calendar year				
Form/class				

Dear Parent/Guardian

Before you complete this form, please read the **Information for the School Entry Health Assessment** sheet, then:

- ☐ **Complete all 4 pages of this form.**
- ☐ **Sign in the box on the back page.** The nurse cannot do the check if you don't sign.
- ☐ **Return the form** in the 'Confidential' envelope to your child's school as soon as possible.

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

Child details

Sex (as on birth certificate): ☐ Boy ☐ Girl ☐ Indeterminate ☐ Other

Preferred pronouns: ☐ He/him/his ☐ She/her/hers ☐ They/them/their

School: _____ Classroom: _____

Familyname: _____ Givenname: _____

Any other names known by: _____ Date of birth: ____/____/20____

Postal address: _____

_____ Postcode: _____

Country/state of birth: _____ Weight at birth: _____

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

Do you identify your child as of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

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

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Dr ☐ Prof

Surname: _____ Given name: _____

Date of birth: ____/____/____ Email: _____

Phone: 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: _____

_____

Confidential record

General Health

Please describe any current or relevant past medical history: _____

_____

_____

Have you seen a health professional about this? ☐ Yes ☐ No ☐ Not applicable

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

_____

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

If yes, what are they? _____

_____

Parent's/Guardian's assessment of child's development

Here are some things that many children can do by the time they turn 4. Tick all 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 themself
- ☐ Talks about things

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 numbers
- ☐ Understands 'same' and 'different'
- ☐ Draws a person with 2 or more body parts
- ☐ Uses scissors
- ☐ Tells you what is going to happen next in a story or 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**? ☐ Yes ☐ No

If yes, what are they? _____

_____

Do you have concerns/worries about your **child's development**? ☐ Yes ☐ No

If yes, what are they? _____

_____

Is your child toilet trained **during the day**? ☐ Yes, all the time ☐ Sometimes ☐ No, not yet

Is your child toilet trained **during the night**? ☐ Yes, all the time ☐ Sometimes ☐ No, not yet

If no, do you have any concerns? _____

_____

Confidential record

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 last test (month/year) _____/20_____

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) _____/20_____

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

If yes, what are they? _____

_____

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) _____/20_____

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

If yes, what are they? _____

_____

Growth

The school health nurse will measure your child's height and weight and calculate their Body Mass Index (BMI).

We will not tell your child the results.

If your child is not within the healthy weight range, 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, what are they? _____

_____

Has your child had a dental check? ☐ Yes ☐ No If yes, date of last check (month/year) _____/20_____

Confidential record

Other Information

In the past 12 months, has your child experienced any of the following:

- ☐ separation/remarriage of parents
- ☐ death of a relative/friend
- ☐ parent/sibling health condition such as mental illness, autism, ADHD
- ☐ parent's loss/change of job
- ☐ move to a new house
- ☐ move to out of home care
- ☐ new baby in the house
- ☐ witnessing violence

If yes, please describe: _____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Would you like the school health nurse to call you to discuss the information you have provided? ☐ Yes ☐ No

If you'd like to be present while we conduct the SEHA, please let us know the best way to contact you to discuss this:

_____

(If you leave this blank, we will conduct the SEHA while your child is at school and let you know the results.)

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** sheet 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: ____/____/20__

Confidential record