**Special School Health Questionnaire and Consent**

As your child is new to this school we would be grateful if you would complete this questionnaire. The aim of the questionnaire is to identify any possible health needs that may affect your child’s ability to achieve in school.

Once completed, please return the questionnaire, in the envelope provided, to the school office. It will be collected and assessed by a member of the Special School Nursing Service. If required, you or your child will be offered a health appointment with a school nurse.

**All information recorded on the questionnaire will remain confidential.**

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| **Child’s Full Name:**  | **DOB:**  |
| **Home Address:**  | **Sex:** Male Female :  |
| **Telephone Number**:Home:Mobile: | **Consent to Text reminders:** |
| **School:**  | **Ethnicity:** |
| **Language spoken:** | **Religion:** |
| **GP Details:**  |
| **NHS Number (if known)** |
| **Allergies:** |
| **Who lives at Home?** Please list everyone who lives at your home address |
| **Name** | **DOB** | **Relationship to child.** | **Parental Responsibility?****Yes / No** |
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| **Q1: Does your child have any health problems / conditions?** | **Yes / No (Please circle). If yes please give details below:** |
| **Q2: Is your child supported by any other professional e.g. consultant, physio, social worker, family support etc.** | **Yes / No (Please circle). If yes please give details below:** |
| **Q3: Does your child require any emergency medicine?** | **Yes / No (Please circle). If yes please give details below:** |
| **Q4: Is your child on any medicine?**  | **Yes / No (Please circle). If yes please give details below:** |
| **Q5: Does your child have any special diet / feeding requirements.**  | **Yes / No (Please circle). If yes please give details below:** |
| **Q6: Does your child suffer with constipation, daytime or night time wetting?** | **Yes / No (Please circle). If yes please give details below:** |
| **Q7: Does your child have a sight or hearing difficulty?**  | **Yes / No (Please circle). If yes please give details below:** |
| **Q9: Does your child see a Dentist?** | **Yes / No (Please circle). If yes please give details below:** |
| **Q10: Do you have any concerns about your child’s (please circle):**HearingSight Height or Weight |  **Yes / No (Please circle). If yes please give details below:** |
| **Q11: Has your child had all their baby/child immunisations?****(If you are unsure you can check this with your GP or within your child’s Red Book)** | **Yes / No (Please circle). If your child has not received their routine childhood immunisations please arrange your GP or practice nurse to arrange to receive these to be given.** |
| **Q12: Do you have any concerns relating to your child? E.g. sleep, anxiety, behaviour etc.** | **Yes / No (Please circle). If yes have they seen anyone about this or are you waiting to be seen?**  |
| **Name of person completing form:** |  | **Signature:** |
| **Relationship to Pupil:** |  |
| **Date completed:** |  |

Office Use only:

Rag rating high, medium or low