Lincolnshire Community Health Services NHS

NHS Trust

School Entrant Health Questionnaire

Please complete BOTH sides of questionnaire in BLOCK CAPITALS using black ink

Child's school	
Child's surname	
Child's first names	
Child's date of birth	/ /

Parent/carer's name (please specify relationship to child)	
Contact telephone number	

Child's NHS number (if known)										

Address Postcode	

Ethnicity

☐ White British	☐ White and Black African	☐ Pakistani	☐ Any Other Black Background
☐ White Irish	☐ White and Asian	☐ Bangladesh	☐ Caribbean
☐ Any Other White	☐ Any Other Mixed Background	☐ Any Other Asian Background	☐ Not Known
☐ White and Black Caribbean	☐ Indian	☐ African	☐ Other

Child's first language ☐ English ☐ Other (please state which language the child speaks)

Parent/carer's first language ☐ English ☐ Other (please state which language Parent/Carer speaks)

Q1. Does your child have a health condition or diagnosis? ☐ Yes ☐ No

If YES, please give details

Q2. Is your child on any medication (such as inhalers or epipen)? ☐ Yes ☐ No

If YES, please give details

Q3. Does your child have any allergies? ☐ Yes ☐ No

If YES, please give details

Q4. Has your child had his/her pre-school booster? ☐ Yes ☐ No

This is usually given around 3 ½ years or soon after. If you are unsure, your GP surgery will be able to tell you if your child has received it.

Q5. Has your child had an eye test in the last year?	☐Yes	☐ No	
Q6. Does your child wear glasses?	☐ Yes	☐ No	
Q7. Does your child have any problems with hearing?	☐Yes	☐ No	☐ *Please tick if you would like any support or advice with this*
Q8. Has your child had a dental check up in the past year?	☐Yes	☐ No	
Q9. Does your child have a problem with day time wetting?	☐Yes	☐ No	*If YES, please see your GP for further advice.*
Q10. Does your child have a problem with night time wetting?	☐Yes	☐ No	☐ *Please tick if you would like any support or advice with this*
Q11. Does your child have a problem with soiling?	☐Yes	☐ No	*If YES, please see your GP for further advice.*
Q12. Do you have any concerns regarding your child's growth (height/weight)?	☐Yes	☐ No	☐ *Please tick if you would like any support or advice with this*
Q13. Do you have any concerns regarding your child's diet/fluid intake?	☐Yes	☐ No	☐ *Please tick if you would like any support or advice with this*
Q14. Do you have any concerns regarding your child's emotional health or behaviour?	☐Yes	☐ No	☐ *Please tick if you would like any support or advice with this*

If YES, please give details

Q15. Do you have any other concerns about your child's health and/or development that you would like to discuss with a member of the school nursing team?	☐Yes	☐ No

If YES, please give details

Signature ....

Date .... / .... / ....

Thank you for taking the time to complete this questionnaire