



Well Child Service Child Health Information

We wish to welcome your child to their new school.

To provide a quality and safe educational experience this form invites information from you about your child's health and/or specific health needs. This information will be helpful to the relevant school staff as well as the Public Health Nurse and Vision Hearing Technician who are associated with the school.

This form also incorporates information and consent for School Based Health Screening if required.

Please complete **both sides of this form** and return to your child's school.

School:		
Name of Student:	Date of Birth:	(Please circle) Male/Female
Also known as:		
Address:	Phone: <i>Hm:</i> _____ <i>Wk:</i> _____	
Postcode:	Mobile:	
Ethnicity: NZ / European <input type="checkbox"/> Maori <input type="checkbox"/> Other _____ Pacific Island <input type="checkbox"/> Asian <input type="checkbox"/>	Parent(s)/Caregiver(s):	
	Family Doctor/Medical Centre:	

Health Information

It is important that staff know of specific needs for your child. Listed below are some common health concerns in children. Tick the relevant box(es) and provide brief comment as required.

- | | |
|---|--|
| <input type="checkbox"/> Frequent coughs or colds | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Skin rashes / Eczema | <input type="checkbox"/> Asthma or wheeze |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eyes or vision <i>Specialist/optometrist care: Yes/No</i> |
| <input type="checkbox"/> Wetting | <input type="checkbox"/> Ear problems <i>Specialist care: Yes/No</i> |
| <input type="checkbox"/> Soiling | <input type="checkbox"/> Behaviour Problems |
| <input type="checkbox"/> Fits/turns | <input type="checkbox"/> Eating difficulty |
| <input type="checkbox"/> Speech/language | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Poor Growth |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |

Medication(s): _____

Other relevant information e.g. Doctors or Specialists/other services involved with your child's health and wellbeing:

Would you like the Public Health Nurse to contact you regarding the above. **Yes** **No**

School Based Vision Hearing Screening

Routine Vision Hearing screening is offered to children who have **not** had this completed as part of the Before School Check (B4SC).

- Do you give consent for this Vision / Hearing screen?

Yes No

NB: you will be advised of the outcome of the above with further information relating to any concerns identified.

Name: _____ **Signed:** _____ **Date:** _____

Immunisation

Immunisation provides your child with protection against many diseases. Immunisation is **free** from your family doctor.

An Immunisation Certificate from your family doctor is required on enrolment at school whether you have chosen to immunise or not. This form is also in the back of the Well Child Book.

Not given: Parental choice Medical reasons other _____

Please tick the vaccinations your child has had.

National Immunisation Schedule 2008			
Age	Vaccines to be given		
<input type="checkbox"/> 6 weeks	DTaP-IPV	Hib-HepB	PCV7
<input type="checkbox"/> 3 months	DTaP-IPV	Hib-HepB	PCV7
<input type="checkbox"/> 5 months	DTaP-IPV	Hib-HepB	PCV7
<input type="checkbox"/> 15 months	Hib	MMR	PCV7
<input type="checkbox"/> 4 years (11 years Tdap)	DTaP-IPV	MMR	

Key: **D:** diphtheria; **d:** adult diphtheria; **T:** tetanus; **aP:** acellular pertussis; **ap:** adult dose acellular pertussis;
Hib: *Haemophilus influenzae* type b; **Hep B:** hepatitis B; **IPV:** inactivated polio vaccine;
MMR: measles, mumps, rubella; **PCV7:** pneumococcal

If you have any questions or concerns regarding your child's health please don't hesitate to contact the Well Child Service at 03 211 0012; your local contact as in the blue insert or ask your school administration for the local number.

Thank you.