Primary School Health Record

Hearing

Is there a history of hearing problems during childhood in other family members on either side of the family?
☐ Yes ☐ No

If yes, please indicate_____

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

If yes, please indicate_____

Has your child had any of the following? *(mark all that apply)*
☐ Repeated ear infections ☐ Discharging ears ☐ Hearing loss ☐ Grommets

Other ear operation_____

Has your child received or are they receiving medical care for his/her ears/hearing?
☐ Yes ☐ No

If yes please describe_____ Date of last appointment (month/year)___/___

General health

Does your child have any ongoing health or physical problems? ☐ Yes ☐ No

If yes, what are they?_____

Have you completed a student health care plan? ☐ Yes ☐ No

Has this condition been attended to by a health professional? ☐ Yes ☐ No

If yes, please provide his/her contact details_____

_____

Is there any other information you feel would be helpful for the Community Health Nurse (for example, changes or major events in the family)?

_____

_____

_____

_____

_____

_____

Progress Notes

Office use only:

Child's name:_____ DOB:___ /___ /_____

Date, time and location	Comment	Name, signature and designation

Confidential Record

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

School Entry Health Assessment

Office use only

Surname:_____ Given name:_____

Date of Birth:___/___/20___

UMRN:_____

Retain Until: 20_____

☐ No assessments conducted or required

Academic year	K	P	1	2	3	4	5	6
Calendar year								
Form/class								

Dear Parent/Guardian

The School Health Service is pleased to offer health assessments for children starting school.

Please complete this form to assist the Community Health Nurse to identify which (if any) assessments are required for your child.

If a health concern is identified by you or your child's teacher, assessments may be carried out by a Community Health Nurse at your child's school. These may include:

- **Vision assessment** – this includes testing your child's distance vision and using a small light to look into the eye and watching the movements of the eye
- **Hearing assessment** – this includes testing your child's hearing and looking into the ear canal
- **General developmental health assessment** – this is a brief assessment of any developmental or health related concerns based on the information provided by you on this form or a concern noted by the teacher.

You will receive the results of any assessments undertaken and the Community Health Nurse will contact you if any further action is needed. This may include a follow-up assessment, or a referral to other services.

Please complete this form and sign below. Return the form to your child's school as soon as possible.

Important

I have read and understand the above letter and consent to:

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

Signature of parent or guardian:_____ Date___/___/20___

Name:_____ Relationship to child:_____

If you would like help completing this form, please contact the Community Health Nurse at your child's school.

(Please tick if you would like a copy of this letter translated into Chinese/Arabic/Vietnamese)

如果你想看本函的中文译本，请在方框上打钩。 ☐ *(Chinese)*

اذا كنت ترغب في الحصول على نسخة من هذه الرسالة باللغة العربية، يرجى وضع علامة في ☐ *(Arabic)*

Xin vui lòng đánh dấu vào ô vuông nếu bạn cần lá thư này bằng tiếng Việt ☐ *(Vietnamese)*

Please complete details inside

CHS409-1
10/16

Confidential Record

Particulars of child

☐ Boy ☐ Girl

School:_____

Surname:_____

First name:_____ Preferred name:_____

Postal address:_____

Postcode:_____ Child's date of birth:____/____/ 20____ Weight at birth:_____

Country/state of birth:_____

Child's Medicare no: ☐☐☐☐ ☐☐☐☐☐ ☐ Child's reference no: ☐

Is your child of Aboriginal origin? ☐ Yes ☐ No

Child's brothers or sisters:

1. Full name:_____ Date of birth:____/____/20____
2. Full name:_____ Date of birth:____/____/20____
3. Full name:_____ Date of birth:____/____/20____
4. Full name:_____ Date of birth:____/____/20____
5. Full name:_____ Date of birth:____/____/20____

Parent or guardian for contact

☐ Mother ☐ Father ☐ Guardian

Surname:_____ First name:_____

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

Email:_____

Mother's country of birth:_____ Father's country of birth:_____

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:_____

_____

Immunisation

Australian Immunisation Register (AIR)
It is an enrolment requirement to 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 phoning AIR on 1800 653 809.

Has your child had the 4 year old immunisation? Did you know your child can have their 4 year old immunisation from 3½ years of age?

Parents' Evaluation of Developmental Status (PEDS)

Please list any concerns about your child's learning, development and behaviour.

_____

Do you have any concerns about how your child talks and makes speech sounds?
Circle one: No Yes A little Comments:_____

Do you have any concerns about how your child understands what you say?
Circle one: No Yes A little Comments:_____

Do you have any concerns about how your child uses his or her hands and fingers to do things?
Circle one: No Yes A little Comments:_____

Do you have any concerns about how your child uses his or her arms and legs?
Circle one: No Yes A little Comments:_____

Do you have any concerns about how your child behaves?
Circle one: No Yes A little Comments:_____

Do you have any concerns about how your child gets along with others?
Circle one: No Yes A little Comments:_____

Do you have any concerns about how your child is learning to do things for himself/herself?
Circle one: No Yes A little Comments:_____

Do you have any concerns about how your child is learning preschool or school skills?
Circle one: No Yes A little Comments:_____

Please list any other concerns:_____

_____

_____

Have any of these issues been assessed/addressed previously? ☐ Yes ☐ No

If yes, when and by whom?_____

Office use only

PEDS score	A	B	C	D	E

Vision

Has your child has a vision test with a doctor, nurse, optometrist or orthoptist?

☐ Yes ☐ No If yes, please indicate_____

Do you have any concerns regarding your child's eyes or eyesight? ☐ Yes ☐ No

If yes, please indicate_____

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 with glasses? ☐ Yes ☐ No

If yes, when should they be worn?_____

Has your child received or is she/he receiving medical care for his/her eyes or eyesight?

☐ Yes ☐ No

If yes please describe_____ Date of last appointment (month/year) ____/____/20____

Please continue over page