Dear Parent/Guardian,

The School Health Service is pleased to offer health assessments for your child. With your permission, the following will be carried out by a Community Health Nurse at your child’s school:

- **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 health related concerns based on the information provided by you on this questionnaire or concerns noted by the teacher or nurse).

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 if needed.

If you agree to your child being assessed by the Community Health Nurse, please complete the inside of this form and sign below. Please return it to your child’s school as soon as possible.

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**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; and
- A copy of the assessment results being kept with my child’s academic record; and
- 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 you like a copy of this letter translated into Chinese/Arabic/Vietnamese)

- [ ] (Chinese)
- [ ] (Arabic)
- [ ] (Vietnamese)

Confidential Record
Particulars of child

☐ Boy  ☐ Girl

School:_____________________________________

Surname:____________________________________

First name:_________________  Preferred name:_________________

Postural 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:________________________________  Year of birth:________
2. Full name:________________________________  Year of birth:________
3. Full name:________________________________  Year of birth:________
4. Full name:________________________________  Year of birth:________
5. Full name:________________________________  Year of birth:________

Parent or guardian for contact

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 Childhood Immunisation Register (ACIR)

You are reminded that it is an enrolment requirement that you provide a current copy of your child’s ACIR Immunisation History Statement to the school. You can obtain this information by contacting ACIR on 1800 653 809 or email acir@humanservices.gov.au

Has your child had the 4 year old immunisation? Did you know your child can have their 4 year old immunisation from 3 ½ years of age?

Confidential Record
Primary School Health Record

Vision

Is there a history of vision problems during childhood in other family members on either side of the family?  
☐ 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)___/____

Hearing

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, please indicate_____________________________________________________________

• Has this condition been attended to by a health professional?  ☐ Yes  ☐ No  
  If yes please indicate_____________________________________________________________

Have you completed a student health care plan?  ☐ Yes  ☐ No  
• Do you consider your child to be:  ☐ Healthy weight  ☐ Underweight  ☐ Overweight

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

_________________________________________________________________________________
Primary School Health Record

Parents' Evaluation of Developmental Status (PEDS)

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

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

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

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

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

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

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

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

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

10. 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

Progress Notes

Office use only:

<table>
<thead>
<tr>
<th>Child's name:</th>
<th>DOB: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date, time and location</td>
<td>Comment</td>
</tr>
<tr>
<td>Name, signature and designation</td>
<td></td>
</tr>
</tbody>
</table>