NHS Scotland
Medical-In-Confidence

CHILD HEALTH SCREENING PROGRAMME - SCHOOL
PRIMARY 1 HEALTH REVIEW QUESTIONNAIRE

Printed:

Name:
DoB/CHI No:
School:
School No:
Class Year:
Class Reg:

Address

Sex:

GP Practice:

Please check the information above and, if appropriate, enter amendments below. Advise the family to notify the GP of any changes.

Change of name: _____

Change of School: _____

Change of GP Practice: _____

Change of address: _____

_____

Postcode ☐☐☐☐☐☐☐

In line with the NHS (Scotland) Act 1978, health reviews are offered to all school aged children in Scotland. Your child is now being offered their Primary 1 health review.

The Primary 1 health review includes:

- A questionnaire for parents/carers about their child's health (this form)
- A height and weight check
- An opportunity for contact with the school nursing team
- If required, an eyesight check may also be offered.

If this is in the best interest of your child, and following disucssion with you, we will share relevant information gathererd through the review with appropirate professionals to ensure we can provide necessary support to your child.

IF YOU DO **NOT** WANT YOUR CHILD TO RECEIVE THEIR PRIMARY 1 HEALTH REVIEW, PLEASE PHONE - **01506 771859 / 860**

If you DO NOT contact us, we will undertake this health review.

Please complete the questions below and return this form to the school for the attention of the school nursing team as soon as possible.

Name of Parent/Carer: _____

Parent/Carer Daytime Phone Number: _____

HAVE YOU CONCERNS ABOUT ANY OF THE FOLLOWING (Please give brief details)

General Health: _____

Growth and Development: _____

Weight: _____

Behaviour: _____

Please Turn Over
Version Number

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES/ACCIDENTS (within last 6 months)? YES ☐ NO ☐

If Yes, please give details _____

_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

Severe allergy	YES ☐	NO ☐	Problems with eyesight	YES ☐	NO ☐
Severe epilepsy, convulsions, fainting turns	YES ☐	NO ☐	Bedwetting	YES ☐	NO ☐
Problems with hearing	YES ☐	NO ☐	Soiling	YES ☐	NO ☐
Problems with speech	YES ☐	NO ☐	Emotional problems	YES ☐	NO ☐
Coordination/movement difficulties	YES ☐	NO ☐	Any other health problems	YES ☐	NO ☐

If Yes, please give details _____

_____

IS YOUR CHILD CURRENTLY ATTENDING HOSPITAL/CLINIC? YES ☐ NO ☐

If Yes, please give details _____

IS YOUR CHILD ON ANY TREATMENT/MEDICATION AT PRESENT YES ☐ NO ☐

If Yes, please give details _____

IF YOU WOULD LIKE TO SPEAK TO A HEALTH PROFESSIONAL ABOUT YOUR CHILD, PLEASE PHONE THE NUMBER OVER THE PAGE

If the school nursing team want to talk to you about your child's health, they will contact you directly.

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM

The information you have given us will be treated in strictest confidence.