

During your child's school-days, his/her health will be checked at regular intervals. You will be very welcome to attend the first medical examination, which will take place shortly.

School

Child's name

School or pre-school previously attended

No. of living children in family boys girls

Position of this child

Date of birth / /
day month year

Occupation of father

Occupation of mother

It would be helpful to have the following information concerning the child's health.

Present health

Does your child suffer from—

- | | | | | | |
|---------------|-----------------------------|------------------------------|----------------|-----------------------------|------------------------------|
| Colds? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Coughs? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Sore throats? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Snoring? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bedwetting? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Worms? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Headache? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Sleeplessness? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Any other complaint? No Yes:

Does the child tire easily? No Yes

Is the appetite good? No Yes

Past medical history

Has your child had—

- | | | | | | |
|------------------|-----------------------------|------------------------------|--------------------|-----------------------------|------------------------------|
| Measles? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Mumps? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diphtheria? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | German measles? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Whooping cough? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Chicken pox? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Rheumatic fever? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | St. Vitus dance? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Scarlet fever? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Pneumonia? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Earache? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Any other illness? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Any injury? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Any operations? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Immunisation

Has your child been immunised against—

- | | | | | | |
|-----------------|-----------------------------|------------------------------|--------------------|-----------------------------|------------------------------|
| Diphtheria? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tetanus? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Whooping cough? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Poliomyelitis? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Small pox? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Any other disease? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

May your child take goitre tablets? No Yes

Any other remarks:—

Parent's signature

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Address

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Date

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>day</i>			<i>month</i>			<i>year</i>			

SCHOOL SISTER'S NOTES

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HEALTH CARD (10 year age group)

School Grade

Child's name

Date of birth / /
day month year

Your child will soon be due for another School Medical Examination. It would be appreciated if you could give some additional information about her health to bring our records up to date.

1. Immunisation record

Has your child received any immunisation No Yes
SINCE commencing school?

(N.B.—Please do not list injection received in infancy or before starting school.)

Diphtheria	Full course	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Booster	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Tetanus	Full course	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Booster	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Poliomyelitis	Full course	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Small pox	1st vaccination	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Re-vaccination	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Any other		<input type="checkbox"/> No	<input type="checkbox"/> Yes

2. Illness since commencing school

3. Does the child now suffer from:

Sore throats?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Colds?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Earache?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Deafness?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Headache?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Poor vision?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bedwetting?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Behaviour difficulties?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

4. Are you concerned about any other aspects of your child's health?

Parent's signature

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Address

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Date

		/			/				
<i>day</i>			<i>month</i>			<i>year</i>			