Department of Health Services, Tasmania

Serial No. | | | | | | |

Student names First names

Surname

Sex ☐ Male ☐ Female

Student DOB | | / | | / | | | | |
day *month* *year*

Parent names First names

Surname

Address

Family doctor

Change of address

Year	Child only
Year	Whole family

Schools

Year	School	Grade

Examinations

Medical					Sister				
Year	Date	Year of Exam.	Remarks	Initials	Year	Date	Year of Exam	Remarks	Initials

Year	Grade	Eyes	Ears	Height (Ins.)	Weight (lb.)	Chest Exp.	Goitre Tabs.

Date	Medical officer	Child's serial number
☐☐ / ☐☐ / ☐☐☐☐ (day / month / year)	No.	☐☐☐ ☐☐☐

Child's name ☐

School ☐ No. ☐☐☐

Type of examination	Entry ☐	Age-grp. ☐	Review ☐	Special ☐	
Parent present ☐	Sex Male ☐	Female ☐	Year of birth ☐☐☐☐		

		Code	T	H.T.	Obs.	Not.
General condition		G	A	B	C	D
Eyes	Vision	A-1				
	Squint	A-2				
	Other	A-3				
Ears	Deafness	A-4				
	Other	A-5				
Skin		A-6				
Hair		A-7				
Allergy		A-8				
Orthopaedic	Posture	A-9				
	Limbs	A-11				
	Other	A-12				
Thorax	Type of heart defect	B-1	C	R	F	
	Heart					
	Lungs	B-2				
	Other	B-3				
Nose & throat	Palate	B-4				
	Nasopharynx	B-5				
	Tonsils	B-6				
	Other	B-7				

		Code	T	H.T.	Obs.	Not.
Thyroid scale		T	0	1	1+	2
Goitre tablets		T	1	2	3	
Thyroid	Action	C-1				
Abdomen	Scars	C-2				
	Viscera	C-3				
	Hernia	C-4				
	Genitalia	C-5				
Nutrition	Overweight	L-1				
	Underweight	L-2				
	Pallor	L-3				
Glands		L-4				
Anaemia		L-5				
Speech		L-6				
Nervous system		L-7				
Intelligence		Q	A	B	C	D
Behaviour		M-1				
Teeth	Deciduous	M-2				
	Permanent	M-3				
	Malocclusion	M-4				
	Dental hygiene	M-5				
Gums		M-6				
Any other condition		M-7				

Clinical Notes (refer to code numbers)

Doctor’s Report to be Gummed to this Page

School Sister's Notes

First visit report complete ☐☐ / ☐☐ / ☐☐☐☐

day *month* *year*

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?	☐ No	☐ Yes	Coughs?	☐ No	☐ Yes
Sore throats?	☐ No	☐ Yes	Snoring?	☐ No	☐ Yes
Bedwetting?	☐ No	☐ Yes	Worms?	☐ No	☐ Yes
Headache?	☐ No	☐ Yes	Sleeplessness?	☐ No	☐ 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?	☐ No	☐ Yes	Mumps?	☐ No	☐ Yes
Diphteria?	☐ No	☐ Yes	German measles?	☐ No	☐ Yes
Whooping cough?	☐ No	☐ Yes	Chicken pox?	☐ No	☐ Yes
Rheumatic fever?	☐ No	☐ Yes	St. Vitus dance?	☐ No	☐ Yes
Scarlet fever?	☐ No	☐ Yes	Pneumonia?	☐ No	☐ Yes
Earache?	☐ No	☐ Yes	Any other illness?		
Any injury?	☐ No	☐ Yes	Any operations?	☐ No	☐ Yes

Immunisation

Has your child been immunised against—

Diptheria?	☐ No	☐ Yes	Tetanus?	☐ No	☐ Yes
Whooping cough?	☐ No	☐ Yes	Poliomyelitis?	☐ No	☐ Yes
Small pox?	☐ No	☐ Yes	Any other disease?	☐ No	☐ Yes

May your child take goitre tablets? ☐ No ☐ Yes

Any other remarks:—

Parent's signature

Address

Date ☐☐ / ☐☐ / ☐☐☐☐
day *month* *year*

SCHOOL SISTER'S NOTES

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 SINCE commencing school? ☐ No ☐ Yes

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

Diptheria	Full course	☐ No	☐ Yes
	Booster	☐ No	☐ Yes
Tetanus	Full course	☐ No	☐ Yes
	Booster	☐ No	☐ Yes
Poliomyelitis	Full course	☐ No	☐ Yes
Small pox	1st vaccination	☐ No	☐ Yes
	Re-vaccination	☐ No	☐ Yes
Any other		☐ No	☐ Yes

_____

2. Illness since commencing school

3. Does the child now suffer from:

Sore throats?	☐ No	☐ Yes	Colds?	☐ No	☐ Yes
Earache?	☐ No	☐ Yes	Deafness?	☐ No	☐ Yes
Headache?	☐ No	☐ Yes	Poor vision?	☐ No	☐ Yes
Bedwetting?	☐ No	☐ Yes	Behaviour difficulties?	☐ No	☐ Yes

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

Parent's signature

Address

Date / /

day *month* *year*