 **Your Child’s Health Questionnaire**

The school nurses would appreciate you completing this form.

Please return to [Livewell.snhealthquestionnaires@nhs.net](mailto:Livewell.snhealthquestionnaires@nhs.net)

LSW is committed to maintaining your privacy and confidentiality; for more details on how we use your information please visit:

[https://www.livewellsouthwest.co.uk/wp-content/uploads/2019/04/Privacy-Statement-2019-v2.0-CF.docx](https://www.livewellsouthwest.co.uk/wp-content/uploads/2019/04/Privacy-Statement-2019-v2.0-CF.docx%20)

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| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |  | | **Date of**  **Birth:** |  | |
| **School:** |  | |
| **Home Address including Postcode:** | | | **Gender:** |  | |
| **Ethnicity:** |  | |
| **Please gives us details about how we can contact you:** | | |  |  | |
| **Home Tel:** |  | | **Main Language:** |  | |
| **Mobile Tel:** |  | | **Do you require an interpreter?** | **Yes / No** | |
| **We might occasionally send you text reminders or requests? Please state No if you do not want to receive these:** | | | **Religion:** |  | |
| **Parent/Guardian’s email:** | | | | | **Date Form Completed:** |
| **Name of Parent/ Guardian** | |  | | | **Relationship to child:** |

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| For further information about the services offered by the School Nursing Service visit the website: [**https://www.livewellsouthwest.co.uk/childrens-services/schools**](https://www.livewellsouthwest.co.uk/childrens-services/schools)  If your child has any health or behaviour concern that you would like to speak to a member of the team about:  Please call **01752 434008** or email[**livewell.phnadminhub@nhs.net**](mailto:livewell.phnadminhub@nhs.net) |

**Please Turn Over and Complete Back Page.**

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| **Do you have any concerns for your child with any of the following:-** | | |
| **Concern** |  | **If “Yes” please provide details of concern and any current support your child may already have:** |
| Behaviour | **Yes/ No** |  |
| Physical development | **Yes/ No** |  |
| Eating | **Yes/ No** |  |
| Growth | **Yes/ No** |  |
| Daytime wetting | **Yes/ No** |  |
| Bed wetting | **Yes/ No** |  |
| Soiling | **Yes/ No** |  |
| Constipation | **Yes/ No** |  |
| Hearing | **Yes/ No** |  |
| Sleeping | **Yes/ No** |  |
| Other health concerns | **Yes/ No** |  |

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| **Office Use Only** | | | | |
| **Date Received** | **Date Assessed** | **Assessed by** | **NFA** | **First Line Advice** |
|  |  |  |  |  |