

**ALLERGIES**

Does your child have an allergy, eg. food, bees, medications etc?  Yes  No  
If 'Yes' what is it and what happens? \_\_\_\_\_  
Do they have an action plan?  Yes  No  
What medications do they need? \_\_\_\_\_  
Comments: \_\_\_\_\_

**BEHAVIOUR**

Does your child have any behavioural problems?  Yes  No  
Comments: \_\_\_\_\_

**BOYS** *We realise this is a sensitive question, but it's VERY important.*

Are both testes down in the scrotum? (Check after a warm bath)  Yes  No  
Is the foreskin easily moved back?  Yes  No

Comments: \_\_\_\_\_

**DENTAL**

Is your child enrolled at a dental clinic?  Yes  No  
Comments: \_\_\_\_\_

**OTHER**

Does your child have any other conditions or disabilities?  Yes  No  
Comments: \_\_\_\_\_

Name of parent/caregiver: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_

Please return completed form to your child's school.  
Thank you.

August 09

To the parent or guardian of \_\_\_\_\_  
Public Health Nurses review new entrants health to identify any concerns that may impact on learning. Can you please complete this form and return it to your child's teacher.  
Enclosed is an information leaflet for you to keep.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: F / M  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Ethnic Group: \_\_\_\_\_ GP: \_\_\_\_\_  
School: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Parent/caregiver names: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child have brothers or sisters?  Yes  No  
Names: \_\_\_\_\_ Ages: \_\_\_\_\_  
Did your child attend Preschool / Kohanga Reo?  Yes  No  
Name of Centre: \_\_\_\_\_ Time spent there: \_\_\_\_\_

Has your child had a B4 School check?  Yes  No  
Are there any concerns/issues for which you would like assistance?  Yes  No  
If Yes, please list: \_\_\_\_\_  
Can we contact your child's GP to discuss the results?  Yes  No

Are your child's immunisations up to date?  Yes  No  
Please tick which immunisations they have had:  
 6 week  3 1/2 month  5 month  15 month  4 year  
Meningococcal B  Dose 1  Dose 2  Dose 3  
Has your child spend time in hospital?  Yes  No  
Details: \_\_\_\_\_  
Does your child take any regular medications?  Yes  No  
Please state what medications are and when taken: \_\_\_\_\_  
Do you have any concerns about your child's height or weight?  Yes  No



**Public Health Centre**  
*Health for All - Hauora ā Iwi*

# WELL CHILD New Entrant Health Form

Whanganui  
District Health Board  
Phone: 06 348 1775

Please fill in this form and return it to school.

**EARS**

Does your child ..  
Hear you?  Yes  No  
Have earache often?  Yes  No  
Have runny ears?  Yes  No  
Comments: \_\_\_\_\_

**EYES**

Does your child ..  
Rub their eyes /screw up eyes /tilt head back to see / have headaches?  Yes  No  
Do you feel your child sees well?  Yes  No  
Do both eyes look straight ahead all the time?  Yes  No  
Comments: \_\_\_\_\_

**SPEECH**

Does your child ..  
Speak clearly?  Yes  No  
Comments: \_\_\_\_\_

**CHEST**

Does your child ..  
Have a cough or snore at night?  Yes  No  
Become short of breath after exercise?  Yes  No  
Have asthma?  Yes  No  
If 'Yes' is your child on inhalers / puffers?  Yes  No  
What, and when are they taken? \_\_\_\_\_  
Comments: \_\_\_\_\_

**SKIN**

Does your child ..  
Have eczema / skin rashes?  Yes  No  
What creams / medications are they on? \_\_\_\_\_  
Comments: \_\_\_\_\_