Redbridge Children's Integrated Universal and Early Intervention Services
Screening Questionnaire

Name of Child: …… **Date of Birth:** ……

NHS Number: …… **Sex:** Male / Female

Address: ……

…….. **Postcode:** ……

Telephone (Home): …… **Mobile:** ……

Parents Email: ……

School: …….. **Class:** ……

General Practitioner (GP) …… **GP Telephone Number:** ……

GP Address: ……

(1) Immunisations
Has your child had all due immunisations to date including **Pre School booster and MMR 2?** **Yes / No**
If no, what Vaccinations has your child **not** had:……

(2) Has your child been diagnosed with?
- Asthma **Yes / No**
- Epilepsy **Yes / No**
- Blood/Clotting Disorder **Yes / No**
- Diabetes **Yes / No**
- Other **Yes / No**

If yes, please give details: .....

(3) Is your child taking any regular medication? **Yes / No**
If yes, please give details: ……

(4) Has your child had a <u>severe/life threatening</u> allergic reaction? **Yes / No**
If yes what is your child allergic to: ……

(5) Has your child been prescribed emergency medication? **Yes / No**
If yes, please give details: ……

(6) Do you have concerns about any of the following with regard to your child?
- Behaviour **Yes / No**
- Soiling **Yes / No**
- Hearing **Yes / No**
- Bedwetting **Yes / No**
- Speech **Yes / No**

If yes, please give brief details: ……

(7) Is there a family history of childhood vision problems under the age of 8 years?
Parents **Yes / No** Siblings **Yes / No**
If yes, please give brief details……

(8) Do you have any concerns regarding your child's growth or development? **Yes / No**
If yes, please give brief details. ……..

(9) Does your child have a regular dental check-up? **Yes / No**
Date of last appointment……

If you have any further concerns about your child, please <u>do not hesitate</u> to contact your School Nurse on 0300 300 1666

Kindly complete and return to the School Office marked for the attention of the School Nurse