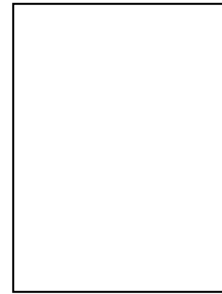

Photo de l'enfant

Secondary : Mrs. Daggy Ries
Nursery & Primary : Mrs. Fabienne Schlim et Mrs. Heidi Glente

SCHOOL MEDICAL SERVICE

CONFIDENTIAL QUESTIONNAIRE TO COMPLETE AND RETURN TOGETHER WITH A COPY OF THE VACCINATION

PERSONAL INFORMATION

NAME of child: …………………………………………..… FIRST NAME: …………….…………………..…

DATE of birth: ……………………………………………. PLACE of birth: ……….……………….…..……….

NATIONALITY: …………………………………………. SEX: Masc. ☐ Fem. ☐

Cycle: ………………………………….. Class: ………………………Language section ………………………...

ADDRESS: …………………………………………………………………………………………………….

NAME of parent or guardian: ………………………………………………………………………….....

ADDRESS: ………………………………………………………………………………………………......

NAME of current doctor: ………………………..……………………………………………………….

CONTACT DETAILS

Tel Mother: Private: ……………………………….. Office : ………………………………..

Mobile : : ..……………………………………………………………………………

Tel. Father: Private: ……………… Office : …………………………...……

Mobile :…………………………………………………….…………..………..……

Contact details of another person who has your permission to collect your child in case we are unable to reach you.

NAME: ……………………………………………………………………………………………….………..

Tel : Private : …………………… Office: …………………………………

Mobile: ………………………………………………………………………….

FAMILY HISTORY

FATHER

Name:……………………………………………………First name…...…………………………………………

Date of birth: …….……………………………………Place of birth: …..…..……………………………………

Profession: ..……….…….……………………………State of health: …….……………………………………...

Height : (cm) : ……………………………………………

MOTHER

Name:……………………………………………………First name……...…………………………………………

Date of birth: ……….……………………………………Place of birth: ..……….……………………………………

Profession: …...…….…………………………………State of health: ..…………………...……………………...

Height : (cm) ……………………………………………...

Siblings

Names	Place and date of birth	State of health

Has a member of the immediate family died? Yes/No

If yes, was it due to accident or illness? :…………………………………………………………………..

PREVIOUS MEDICAL HISTORY

Circumstances surrounding the birth and development

Was the child born at term? Yes/No
Before term ? Yes/No
After term? Yes/No
Was it a natural delivery? Yes/No
By Caesarean Section? Yes/No
With forceps? Yes/No
With ventouse suction ? Yes/No
Did the child have to be resuscitated? Yes/No
Was the child jaundiced? Yes/No
Were there any breathing, digestive or any other difficulties? Yes/No
Were there any malformations at birth ? Yes/No

Comments if yes………………………………………………………………………………………………

WEIGHT at birth……………………………………...…LENGTH at birth………………………………………

Did your child walk unaided by the age of 18 months? Yes/No
Does your child have any of the following problems?:
A developmental delay? Yes/No
Hyperactivity ? Yes/No
Psychological or behavioural problems ? Yes/No
Any syndrome ? Yes/No
Other problems other than those listed above? Yes/No

………

Infectious Illnesses
Has your child suffered from any of the following illnesses? If yes, please indicate the date:

Measles: ....

Rubella: …………………...

Chickenpox: ……………….

Mumps: ….…………..…….

Scarlet Fever: ………………

Rheumatic Fever :………..…

Viral or bacterial Meningitis: ……………....…….………..

Viral Hepatitis: ……………………………………………..

Bronchopneumonia: ....

Bronchitis: ……………………………....……………..

Repeated Otitis: …………………...……………………..

Repeated Tonsilitis :…………….……………………..

Chronic Illnesses, Hospitalisations and Injuries

Allergies* Yes/No
Specify if yes...…………………………….

……………………………..……………

Hypersensibilites Yes/No
Specify if yes...…………………………….

………………..……………………………
Asthma Yes/No
Eczema Yes/No
Hay fever Yes/No

Has your child had :
Any surgical interventions ? Yes/No
Injuries/Trauma? : Fractures Yes/No
Burns Yes/No
Admissions to hospital ? Yes/No

Convulsions Yes/No
Epilepsy Yes/No
Diabetes Yes/No
Parasitism : Head lice Yes/No
Oxyuriasis (Worms) Yes/No
Cardiac problems? Yes/No
Digestive Problems ? Yes/No
Urinary problems? Yes/No

Other illnesses……………………………………

…………………………………….………………..

…………………………………….………………..
Specify if yes: …..
Specify if yes: …..
Specify if yes: …..
Specify if yes: ……………………………………

*In case of serious dietary allergy a medical report must accompany this form together with an individual protocol of care in case of a reaction whilst at school signed by your doctor.
It is not possible for meals to be prepared specifically for children with dietary allergies whilst at school.
It is the responsibility of the parents for the preparation of meals for children with allergies.

CURRENT STATE OF HEALTH

Is your child in good health? Yes/No
Specify if no:………………..

Does he/she speak correctly? Yes/No
Does he/she have any difficulty with pronunciation? Yes/No
Does he/she stutter? Yes/No
If yes, does this occur often? ....

Is the language spoken at home the same as at school? Yes/No

Is he/she completely independent when going to the toilet? Yes/No
If no, what problems persist? ....

Does your child sleep well? Yes/No from…………………to..…………….………..
If no, what trouble does he/she have? ....

(For older girls) Has your daughter started menstruating? Yes/No

Does he/she sleep with their mouth open? Yes/No

Is he/she often sad? Yes/No

Does he/she sleep in his/her own room?	Yes/No	withdrawn?	Yes/No
Does he/she sleep in his/her own bed?	Yes/No	anxious?	Yes/No
Is he/she nervous ?	Yes/No	indifferent?	Yes/No
Is he/she often angry?	Yes/No	aggressive ?	Yes/No
Does he /she often cry?	Yes/No		

Does your child prefer to play alone or does he play easily with other children?
……

CURRENT TREATMENT

Is your child currently taking any medication? Yes/No
If yes, please specify which……………………………………………………………………………….
…….

Is he/she receiving physiotherapy ? Yes/No
Has your child had an ophthalmic examination ? (Vision test) Yes/No
Does he/she wear glasses? Yes/No regularly? Yes/No
occasionally? Yes/No
Date of the last vision test? ………………………………………………………………………………

Do you feel that your child hears normally? Yes/No
Is his/her hearing being monitored? Yes/No

Has he /she ever been referred to a:psychologist ? Yes/No
speech therapist? Yes/No
Has your child benefited from a Learning Support service either in or out of the classroom? Yes/No
Has your child benefited from a specially adapted Individual Educational Programme? Yes/No
Comments, if yes ……………………………………………………………………………………………
…….

VACCINATIONS

Please attach a recent copy of the vaccination card.

***

All this information is confidential and cannot be transferred. If the child leaves the school, the parents may recover the form from the Medical Service.

If your child suffers from a chronic disease, it may be important for the child that his/her teachers are well informed about the special care needed.

In case of a serious accident whist your child is at school, he/she will be taken to the hospital by ambulance, accompanied by the professionals of the emergency services. You will be immediately contacted by the school.

Date:…………………………………………….…… Parents' signatures:……………………….……………………

……………………..……………….