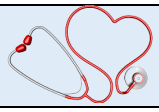
Additional Information - Nursery Starter

Childs Name	
Gender	
Date of Birth	
NHS Number (if known)	

MEDICAL INFORMATION



Are your child's immunisations all up to date? (Please delete as appropriate)

MMR? Y/N	Pre School Booster? Y/N

Does your child suffer with any of the following conditions (please tick all those relevant)

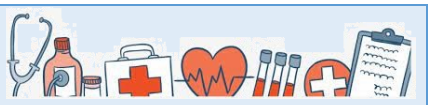
Eczema Heart condition Fits/convulsions Diabetes Speech difficulties
Problems with muscles/bones/joints Severe headaches/migraines Urine infections
Hearing / Vision Hayfever

Are there any other illnesses the school should be aware of (please specify)

Has your child had any serious illnesses/accidents that required hospitalisation:

Please provide any further concerns you would like to mention / ongoing investigation for a medical condition:

MEDICAL INFORMATION Cont.



Is your child taking regular prescribed medication at home (outside school hours) Yes/No
Please specify:

Please provide and further concerns you would like to mention / ongoing investigations for a medical condition:

Does your child have any special medical dietary requirements (as confirmed by a GP):

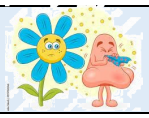
Was your child's 2 year old health check in person or virtual/over the phone?

Does your child have a good sleep routine?

When was your child's last hearing test (approximately)?

When was your child's last eye test (approximately)?

ALLERGIES



What is your child allergic to:

What are the symptoms:

If treatment is needed, please provide details:

ASTHMA

Does your child suffer from Asthma? Yes/No

When was your child diagnosed with Asthma?

What triggers your child's asthma (if known)?

Is your child's asthma (please tick as appropriate) Mild – uses reliever blue inhaler occasionally Moderate – uses preventer and occasionally blue inhaler Severe – uses preventer, regular reliever and other medication

Does your child have disrupted sleep due to his/her asthma (please tick as appropriate)

Rarely Occasionally Frequently

How often is your child seen by the hospital / GP/ Practice Nurse (please tick as appropriate) Only when he/she has an asthma attack On a 3-6 monthly (or more frequent basis) Annual check by GP

What inhalers / medication has your child been prescribed?

Reliever (Name)

Preventer (Name)

Other (Name)

OUTSIDE AGENCIES

Does your child have an Educational Health Care Plan Yes No

Has your family or child had contact with any of the following:-

Child Family Guidance Education Psychologist Yes No

Educational Welfare Officer Yes No

Speech Therapist Yes No

Child Development Centre Yes No

Social Worker Yes No

Other agencies/information the school needs to be aware of (please specify)

CHECKLIST FOR NEW NURSERY CHILDREN

The aim of this section is to let new parents/carers know of the expectations of the school and give you helpful information about school routines. We will be happy to discuss any issues arising from this list with you.

CAN YOUR CHILD	**Yes**	**No**
Put on and do up their shoes?		
Put on and do up their coat?		
Go to the toilet unaided?		
Dress him/herself, including tights or trousers?		
Recognise their name in writing?		

LANGUAGE

What best way describes your child's communication ability?

Gestures only

One word

Full sentences

Other (please specify)

ADDITIONAL INFORMATION

Please use this space to provide any other information that you feel would help us in supporting your child: