



Office use only				
Academic year	K	P	1	2
Calendar year				
Form/class				

School Entry Health Assessment form

Dear Parent/Guardian

Please read the **Information for the School Entry Health Assessment (SEHA)** then:

- complete all 4 pages of this form** using a pen
- sign in the box on the back page.** The nurse cannot do the check if you don't sign.
- return the form** in the 'Confidential' envelope to your child's school as soon as possible.



If you want help with this form or need an interpreter, contact the school health nurse through your child's school office.

Child details

SEX (as on birth certificate): Male Female Indeterminate

Preferred pronouns (optional): He/him/his She/her/hers They/them/their Other _____

School: _____ Classroom: _____

Family name: _____ Given name: _____

Any other names known by: _____ Date of birth: ____ / ____ /20____

Postal address: _____

Postcode: _____

Country/state of birth: _____

Child's Medicare no: Child's reference no: Expiry date: ____ / ____

Do you identify your child as of Aboriginal or Torres Strait Islander origin?

- No Yes, Aboriginal Yes, Torres Strait Islander Yes, both Aboriginal and Torres Strait Islander

Child's brothers and sisters:

1. Fullname: _____ Date of birth: ____ / ____ / ____

2. Fullname: _____ Date of birth: ____ / ____ / ____

3. Fullname: _____ Date of birth: ____ / ____ / ____

4. Fullname: _____ Date of birth: ____ / ____ / ____

5. Full name: _____ Date of birth: ____ / ____ / ____

Has your child attended another school previously? Yes No

If yes, name/s of previous schools: _____

Vision

Has anyone in your family had a vision problem? Yes No

If yes, please describe: _____

Has your child had a vision test with a ophthalmologist optometrist or orthoptist? Yes No

If yes, please describe: _____
_____ Date of last test (month/year) ____/20

Has your child had any of the following? (mark all that apply):

Poor sight Squint Turned eye Eye injury Operation on eyes

Has your child been prescribed glasses? Yes No

If yes, when should they be worn? _____

Has your child ever had medical care for their eyes or eyesight? Yes No

If yes, please describe: _____
_____ Date of last appointment (month/year) ____/20

Do you have any other concerns/worries about your child's eyes or eyesight? Yes No

If yes, what are they? _____

Hearing

Has anyone in your family had hearing problems? Yes No

If yes, please describe: _____

Has your child had any of the following? (mark all that apply):

Repeated ear infections Discharge in ears Hearing loss Grommets

Other ear operation – please describe _____

Has your child ever had medical care for their ears/hearing? Yes No

If yes, please describe: _____
_____ Date of last appointment (month/year) ____/20

Does your child have a Ventriculoperitoneal Shunt (Brain drain)? Yes No

Do you have any other concerns/worries about your child's hearing and/or ears? Yes No

If yes, what are they? _____

Growth

Do you have concerns about your child's growth? Yes No

If yes, what are they? _____

The school health nurse will measure your child's height and weight to see how they are growing for their age and sex. We will not share the results with your child.

Teeth and mouth

Do you have concerns about your child's teeth or the inside of their mouth? Yes No

If yes, what are they? _____

Has your child had a dental check? Yes No If yes, date of last check (month/year) ____/20

Child's General Health and Development

Please describe any current or relevant past medical history: _____

Have you seen a health professional about this? Yes No Not applicable

If yes, provide the health professional's contact details: _____

Please describe any parent/brother/sister health conditions such as mental illness, autism, ADHD: _____

Parent's/Guardian's assessment of child's development

Social/Emotional

Please describe any concerns about your child's behaviour or social and emotional development (such as taking turns, aggression, managing emotions, interacting behaviour).

Language/communication

Please describe any concerns about your child's speech or communication (such as talking, being understood by others).

Does your child speak another language at home? Yes No If yes, what language? _____

Learning, thinking, problem solving

Please describe any concerns about your child's learning, thinking, or problem solving skills (such as following instructions, understanding 'same' and 'different').

Movement and physical development

Please describe any concerns about your child's movement skills (such as running, jumping or drawing).

Personal

Please describe any concerns about your child's personal development (such as self-care, hygiene/washing).

Toilet training

Is your child toilet trained **during the day**? Yes, all the time Sometimes Not yet

If not yet, do you have any concerns? _____

Other Information

Has your child experienced any of the following:

- | | |
|---|---|
| <input type="checkbox"/> separation/remarriage of parents | <input type="checkbox"/> move to a new house |
| <input type="checkbox"/> death of a relative/friend | <input type="checkbox"/> move to out-of-home care |
| <input type="checkbox"/> parent's loss/change of job | <input type="checkbox"/> witnessing violence |
| <input type="checkbox"/> new baby in the house | |

If yes, please describe:

If family violence is happening in your home, you need to get help.

1800RESPECT
(24 hours, 7 days)
1800 737 732

Is there anything else you'd like to share with the school health nurse?

Parent or guardian for contact

Parent Legal guardian Relationship to child: (e.g. mother, father, legal guardian): _____

Mr Mrs Miss Ms

Family name: _____ Given name: _____

Date of birth: ____ / ____ / ____ Country of birth: _____

Email: _____

Phone: Preferred: _____ Alternate: _____

Main language you speak at home: _____ Do you need an interpreter? Yes No

What is the best way to contact you: email phone text

Who does your child usually live with? (e.g. both parents, mother only, father only, grandparents)

*Perth Metro and Peel only: select ONE option (required).

Most School Entry Health Assessments (SEHAs) are completed at school during school hours without parents present. If you would like to attend your child's SEHA, appointments are available during school holidays.

Please complete my child's SEHA at school.

OR

I would like to attend my child's SEHA during the school holidays. I understand that the nurse will contact me by phone, text or email. If I do not respond, my child will NOT be screened, even at school.

You will get your child's SEHA results in a sealed envelope, soon after the nurse has completed it.

Sign here

I have read and understand the **Information for the School Entry Health Assessment** sheet and consent to:

- a health assessment of my child by the school health nurse as described
- a copy of the assessment results being kept with my child's school record
- sharing of information about my child between the school health nurse and relevant school and health staff, where it helps in the management of my child's learning, health or wellbeing.

Name (full name of parent or legal guardian): _____

Signature (parent or legal guardian): _____ Date: ____ / ____ /20