

Parent Questionnaire

Dear parents!

Your details will only be seen by the school doctor. They will be treated in strict confidentiality and therefore, in your own interest, should be handed to the doctor in a sealed envelope. A fully completed questionnaire will assist the work of the school doctor.

Family name of pupil _____ First Name _____ - _____

Gender: male * female* Date of birth (DD.MM.YYYY) _____

Name and address of parents (legal guardian): _____

_____ Telephone _____

Employment status of parents: father: yes* no* mother: yes* no*

Year of birth of siblings _____, _____, _____, _____, _____, _____

Are the parents diabetic? father: yes* no* mother: yes* no*

Are the parents overweight? father: yes* no* mother: yes* no*

Which infections has the pupil had?

measles: yes* no* whooping cough: yes* no*

scarlet fever: yes* no* rubella : yes* no*

chicken pox (shingles) yes* no* mumps: yes* no*

jaundice yes* no* other _____

Are there or have there been other illnesses e.g. frequent sore throats, inflammation of the joints, birth defects or heart/circulation, stomach, bowel, lung, kidney, urinary tract, skin and nervous system illnesses.

Please underline the relevant illnesses.

Further details: _____

Operations or permanent consequences from an accident: _____

Regular intake of medication, if yes, which _____

Has the pupil been vaccinated against encephalitis (ticks) yes* no* last vaccination on _____

Further Particulars:

Bronchial asthma	yes* no*	frequent headaches	yes* no*
Allergies (eczema, hay fever, medication, insect allergies)			yes* no*
chronic middle ear inflammation (perforated eardrum)			yes* no*
Diabetes	yes* no*	sight defect	yes* no*
Fainting	yes* no*	hearing defect	yes* no*
Seizures	yes* no*	speech defect	yes* no*
Observations (insomnia, increased snoring, bed wetting, frequent vomiting etc.			yes* no*

Date: _____

Signature of parents (legal guardian): _____