manx care
Kiarail Vannin

10-11 year old Health Review Questionnaire

To Be Completed by Parents

Child's Surname:	Other Names: Known as:
Date of Birth:	Gender:
Address: Post Code:	Contact No:
Relationship to child:	GP Surgery:
School Attended:	Secondary School from September:

General Health

Please mark your answer with an ☒ in the box.	**Yes**	**No**
Allergies & Asthma		
Does your child have any Allergies?	☐	☐
If yes, please give details		
Does your child have Asthma?	☐	☐
Health Conditions		
Does your child have a health condition?	☐	☐
If yes, what professionals are involved in your child's care?		
Name of condition		
Does your child have any special educational needs or disability?		
If yes, please give details?		
Eyesight		
Does your child wear glasses?	☐	☐
Are they seen routinely at eye clinic or by your local optician?	☐	☐

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Please mark your answer with an ☒ in the box.	Yes	No
Hearing		
Does your child have any problems with their hearing?	☐	☐
Are they under the care of ENT or Audiology?	☐	☐
Name of hearing condition		
Dentist		
Is your child registered with a dentist?	☐	☐
If not, please call 642687 for registration advice.		
Has your child visited the dentist in the last year?	☐	☐
Rest, Diet & Physical Activity		
Does your child understand what a healthy diet is?	☐	☐
Is your child physically active for an hour every day?	☐	☐
How many hours sleep does your child get per night?		
Smoking		
Does anyone within your household smoke?	☐	☐
Young Carer		
Does your child help look after someone who is ill or disabled?	☐	☐
Do they attend young carers?	☐	☐
Social and Community		
Does your child have friends outside of school?	☐	☐
Does your child attend any clubs or activities?	☐	☐
Does your child have any problems that you are aware of regarding the following?		
• Sleep	☐	☐
• Bed wetting	☐	☐
• Soiling	☐	☐
• Eating	☐	☐

If you answer yes to any of the above, please give details including any current support you are receiving. .....

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School Nursing Team, Crookall House, Douglas, Isle of Man IM1 3QA
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Please mark your answer with an ☒ in the box.	Yes	No

Social and Community (continued)

Does your child have any problems that you are aware of regarding the following?

• Anxiety	☐	☐
• Emotional Wellbeing	☐	☐
• Anger	☐	☐
• Body image or weight issues	☐	☐
• Puberty	☐	☐
• Self-Harm	☐	☐
• Internet use	☐	☐
• Any other issues you are concerned about?	☐	☐

If you answer yes to any of the above, please give details including any current support you are receiving. .....

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If you would like any support with any of the above, please do not hesitate to contact the School Nursing Team on 693210.

Please sign

Signature of Parent (with Parental Responsibility): .....

Relationship to child: .....

Print Name: ..... Date: .....

Thank you for completing this health review questionnaire
Please return in the pre-paid envelope provided.

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