SKOLHÄLSAN  **School:**
Class:

Child's First Name & Surname	Personnummer/D.O.B.	
Guardian 1 Name	Personnummer/D.O.B.	
Address	Home Telephone	Work Telephone
E-Mail	Mobile Phone	
Guardian 2 Name	Personnummer/D.O.B.	
Address	Home Telephone	Work Telephone
E-Mail	Mobile Phone	
Child's Birth Country	Guardian(s) Birth Country	
Barnavårdscentral (BVC) that the child is registered in, address and Phone Number:		

Does your child suffer from any of the below:

☐ Yes ☐ No Asthma
☐ Yes ☐ No Allergy
☐ Yes ☐ No Eczema
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Cramps
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Vision Impairment
☐ Yes ☐ No Hearing Impairment
☐ Yes ☐ No Difficulty to hold in urine
☐ Yes ☐ No Difficulty to hold in faeces
☐ Yes ☐ No Stomach Problems
☐ Yes ☐ No Develops infections often
☐ Yes ☐ No Other Illness

Does your child have difficulties with any of the below:

☐ Yes ☐ No Recurrent Headaches
☐ Yes ☐ No Diet
☐ Yes ☐ No Sleep
☐ Yes ☐ No Anxiety/Worries
☐ Yes ☐ No Sitting Still
☐ Yes ☐ No Functioning in a group situation
☐ Yes ☐ No Concentration
☐ Yes ☐ No Gross Motor Skills, walking, running, climbing
☐ Yes ☐ No Fine Motor Skills, drawing, cutting, eating
☐ Yes ☐ No Speech

Does anyone in your family have reading and/or writing difficulties?

If you have a son; are both testicles in the scrotum?

Does your child go for regular inspections at a doctor, physiotherapist, optometrist, or any other specialist? If yes, why and what is the name of the specialist and hospital?

Does your child take any medication regularly? If yes, what is it for and which medicine is it?

Other information about your child's health that the school nurse should know about:

Please use the back side of paper for any further comments or questions.

Date	Guardian's Signature