Harrogate and District NHS
NHS Foundation Trust

You matter most

NORTH YORKSHIRE
HEALTHY CHILD PROGRAMME
Growing up healthy in North Yorkshire

Year 6 Health Questionnaire
To Be Completed By Parents

Child's Surname:	Other Names:
Date of Birth:	Sex: Male ☐ Female ☐ NHS Number (if known):
Address: Post Code:	
Name of Main Carer:	Name of person with legal responsibility:
Tel No:	Family Doctor
School:	Secondary School from September

PLEASE MARK YOUR ANSWER WITH AN X IN THE BOX.

General Health

	Yes	No
Does your child have any allergies? If yes please give details?.....	☐	☐
Does your child have any serious health condition? If yes please give details?.....	☐	☐
Does your child have any problems with their eyesight that glasses do not help with?	☐	☐
Does your child have any problems with their hearing that they are not getting help with?	☐	☐
Is your child registered with the dentist?	☐	☐
Has your child visited the dentist in the last year?	☐	☐
In your family does your child help to look after someone who is ill, frail or Disabled?	☐	☐

Immunisations

Please tick which immunisations your child has had – the details should be in your child's red book.
Your Child will be offered year 9 School leavers boost /ACWY and girls year 8 HPV

Age Due	Immunisation	Received
2 months	1st Diphtheria, tetanus, whooping cough, polio, hib	
	Men C	
3 months	2nd Diphtheria, Tetanus, Whooping cough, Polio	
	Men C	
4 months	3rd Diphtheria, Tetanus, Whooping cough, Polio	
School	Men C	
12-18 months	Measles, Mumps, Rubella (1st MMR) 2nd MMR usually at 3 – 5 years	
3 – 5 years	Diphtheria, Tetanus, Whooping Cough, Polio Booster	

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	Yes	No
Have any major events affected your child's life, eg. ill health or death of a family member, family breakdown	☐	☐

If yes please give details ……..

……

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

	Yes	No
Headaches	☐	☐
Sleep	☐	☐
Bedwetting	☐	☐
Soiling	☐	☐
Eating	☐	☐
Smoking	☐	☐

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

……

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During this school year have you had any concerns about your child relating to:

	Yes	No
Sudden changes of mood	☐	☐
Anxiety	☐	☐
Anger	☐	☐
Body image or weight issues	☐	☐
Self Harm	☐	☐
Any other issues you are concerned about?	☐	☐

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

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Please be aware that our school health records are held electronically and could be accessed by other health professionals.

	Yes	No
Are you happy for us to share your child's electronic record with other health professionals eg. GP?	☐	☐
Are you happy for us to view information on your child's record that may have been inputted by other health professionals?	☐	☐

If you would like any support with any of these issues please do not hesitate to contact your Healthy Child Team on 01423 557711 email hhc-tr.5-19admin@nhs.net

Please sign:

Signature ……..Print Name……..Date……..

Thank you for completing this health questionnaire
Please return to school in the envelope provided