Initial health examination for children under school-age seeking asylum

Alle kouluikäisten turvapaikkaa hakevien lasten alkuterveystarkastus [Englanti]

PRELIMINARY INFORMATION (MEDICAL HISTORY)				
Background information	**FAMILY NAME AND GIVEN NAMES:**	**DATE OF BIRTH:**	**UMAREK-NUMBER:**	**COUNTRY OF BIRTH:** In which country was the child born? *Enter country of birth / Unknown*
	FAMILY: Who are the members of the child's family and with whom does the child live? Have there been any changes to the family structure?		**FAMILY STRESSORS:** Are there currently any stressful things in your family life such as loss/bereavement, hardship, or adversities?	
	PLACES OF RESIDENCE: In which countries has the child lived before coming to Finland? *Enter countries of residence / No countries of residence / Unknown*		**CIRCUMSTANCES:** Has the child lived on the street, in a refugee camp, in a reception centre, a detention centre, or prison? *No / On the street / In a refugee camp / In a reception centre / In a detention centre / In prison / Unknown*	

Growth and development	**WEEKS OF PREGNANCY AT BIRTH:** In which week of pregnancy was the child born?	**ESTIMATED NUMBER OF WEEKS OF PREGNANCY AT BIRTH:** Was the child born at full-term (i.e. 37+0 weeks of pregnancy or more) or prematurely (36+6 weeks of pregnancy or less)? *Full-term (37+0 weeks of pregnancy or more) / Prematurely (36+6 weeks of pregnancy or less) / Unknown*	
	BIRTH WEIGHT: What was the child's birth weight? *In Kilograms (to the nearest 10 grams)*	**ESTIMATED BIRTH WEIGHT:** Was the child's weight normal, underweight (<2kg), or overweight (>4kg) at birth? *Normal weight / Underweight (<2kg) / Overweight (>4kg) / Unknown*	
	BIRTH HEIGHT: How tall was the child at birth?	**ESTIMATED BIRTH HEIGHT:** Was the child of normal height, smaller than average (<47cm), or taller than average (>55cm) at birth? *Normal height / Smaller than average (<47cm) / Taller than average (>55cm) / Unknown*	
	REGULARITY OF MOTHER'S PREGNANCY: Were there any abnormalities or difficulties during the pregnancy? *Yes / No / Unknown*		**BIRTH METHOD:** Was the child delivered vaginally or through a Caesarean (c-section) delivery?
	POST-NATAL HEALTH PROBLEMS: Was the child diagnosed with any health problems in the first month after birth? *Yes / No / Unknown*		**DEVELOPMENTAL ABNORMALITIES:** Has the child grown and developed similarly to its peers? *Yes / No / Unknown*

Diseases	**PERCEIVED HEALTH:** How would you describe the child's current state of health? *Very good / Good / Satisfactory / Poor / Very poor*	**DISEASES**: Has the child got any long-term illness or health issue? This might include conditions such as an allergy or a rash. *Enter health condition(s) / None / Unknown*
	TUBERCULOSIS HISTORY: Has the child, a member of the child's immediate family, or a relative been diagnosed with tuberculosis? *Yes / No / Unknown*	**PERIODS OF HOSPITAL CARE AND SURGICAL PROCEDURES**: Has the child had any significant periods of hospital care, surgical procedures, medical investigations, or treatments? *Yes / No / Unknown*

Medication	**CURRENT MEDICATION:** What medication(s) is the child currently taking? Has the child been prescribed any medication(s) that he or she is not currently using?

Current state of health	**SYMPTOMS:** Has the child had any symptoms or problems in the last month? Symptoms may include a loss of appetite, stomach and urinary problems, skin abnormalities, insomnia, or aches and pains. *Yes / No / Unknown*	
	FEVER: Has the child had a fever that lasted for more than three weeks? *Yes / No / Unknown*	**COUGHING**: Has the child coughed up blood or mucus during the last month? *Yes / No / Unknown*
	FUNCTIONAL CAPACITY: Is the child limited from participating in common daily activities by a health problem? *Not restricted / Restricted, but not seriously / Seriously restricted.*	
	VISION: Does the child have a problem with his or her vision that affects his or her ability to carry out everyday activities? *Yes / No / Unknown*	**HEARING:** Does the child have a problem with his or her hearing that affects his or her ability to carry out everyday activities? *Yes / No / Unknown*

Mental welfare	**TRAUMATIC EXPERIENCES:** Some people experience things that can be extremely upsetting and which can even have a long-term impact on their health and wellbeing. I'm now going to ask you about a few of these kinds of experiences. Has the child experienced an emotionally or physically traumatic event or incident? These kinds of events may be, for example, being involved in an accident, being present during violent situations or conflicts, or becoming separated from a guardian. *Yes / No / Unknown*
	INJURIES: Have you / Has the child been injured as the result of an accident or an act of violence? *Yes / No / Unknown*
	EMOTIONAL LIFE: Does the child have any difficulties in his or her emotional life? Issues with our emotional life can include irritability, sadness, anxiety, withdrawal, fear or thoughts that we would be better being dead. Response options: *Not at all / Less than once a year / Every year / Monthly or weekly / Daily / Unknown*
	CONDUCT DISORDER: Does the child have any behavioural problems? How often? Behavioural problems may include aggressive or indifferent behaviour and oppositional defiance (abnormally defiant for their developmental stage). Response options: Not at all / Less than once a year / Every year / Monthly or weekly / Daily / Unknown
	HYPERACTIVITY: Is the child hyperactive or have any difficulties concentrating? How often? Examples of these kinds of issues include an inability to concentrate, hyperactivity, and impulsivity. Response options: *Not at all / Less than once a year / Every year / Monthly or weekly / Daily / Unknown*

Health habits	**CHILD'S BREAST MILK INTAKE:** Is the child currently being breastfed? *Fully breastfed / Partly breastfed / Not breastfed / Unknown*	**CHILD'SWEENING:** When did the child start eating solid food? *Enter the date*	**DIET:** Do you avoid some foods in your child's diet? *Lactose-free or low-lactose / Gluten-free / Vegetarian diet with dairy products and / or eggs / Vegetarian diet with fish / Vegan / Wheat allergy / Milk allergy / Other food allergy / Other special diet*
	SLEEPING ISSUES: Has the child had any sleeping issues in the last month, such as difficulty falling asleep or waking up several times per night? *Difficulty falling asleep / Difficulty staying asleep / Waking up too early in the morning / Disrupted circadian rhythm / Daytime tiredness / Other sleep disorder*		**DENTAL HYGIENE:** How often does the child have his or her teeth brushed? *Twice a day or more often / Once a day / Less than once a day.*
	PASSIVE SMOKING: Is the child exposed to cigarette smoke? *Yes / No / Unknown*		

and reproduction	**CIRCUMCISION:** In some countries, girls/ boys may be circumcised, and this might have impact on the person's health. Has the child been circumcised? *Yes / No / Unknown*	**PARENTAL CIRCUMCISION (DIRECT QUESTION AT PARENT):** Has the mother/father of the child been circumcised? *Yes / No / Unknown*	**CIRCUMCISION PLANS (DIRECT QUESTION AT PARENT):** Have you considered having your child circumcised? *Yes / No / Unknown*

RISK INFORMATION (e.g. drug allergies)

CURRENT STATUS			
SKIN: Are there any skin abnormalities upon examination? *Yes / No / Unknown.*	**BCG-SCAR:** Does the child have a BCG scar (from tuberculosis vaccination)? *Yes / No / Unknown*	**ORAL EXAMINATION:** Are there any abnormalities upon oral examination? *Yes / No / Unknown*	**Other notes regarding current status**

PHYSIOLOGICAL MEASUREMENTS		
WEIGHT (KG):	**HEIGHT (CM):**	**BODY TEMPERATURE:**

VACCINATIONS
PREVIOUS VACCINATIONS: Which vaccinations has the child had before arriving in Finland? *No vaccinations / Some vaccinations / All vaccinations provided in the country of origin*
VACCINATIONS HISTORY:

PLAN	
PLAN:	
FURTHER TREATMENT AND ADDITIONAL TESTING: *Chest X-Ray / Blood screening / Primary medical examination / Reception centre nurse / Doctor / Dentist / Family clinic / School or student health care / Social worker / Other referral or appointment*	
PATHWAY: *Health services / Non-prescription medication / Mental Health / Sexual and reproductive health / Nutrition / Oral health / Other pathway*	
CONSENT TO INFORMATION SHARING *Consent given / Conditional consent / Consent not given*	**CONSENT TO DATA RETRIEVAL** *Consent given / Conditional consent / Consent not given*
SIGNATURE	