

Background information questionnaire for a health examination for the guardians of 1st grade pupils

Your child will soon have a health examination in school health care. The extensive health examination for 1st grade pupils includes discussing the health and welfare of the child and her or his entire family. We will also consider issues related to the child's school attendance and leisure time. We invite guardians to participate in the child's extensive health examination. Your participation is very important.

We wish that you fill out this form and return it according to the instructions given. When a child lives in two homes, both homes can fill out separate forms. If you need additional copies of the form, you may request them from the school nurse. While the questionnaire has been planned to be filled out by guardians, you may also discuss with your child when considering your answers.

We will discuss the topics of the form during the examination. Your replies help us target the health examination based on your family's needs and wishes. Your child will also fill out a separate form related to the health examination.

Filling out the form and answering each individual question is voluntary. The information you provide is confidential and subject to the secrecy provisions of health care. Information regarding the health examination will be entered in patient documents, after which this form will be destroyed. School health care documents are part of the wellbeing services county's patient register.

Pupil

Name	Class
Personal identity code	Language(s) used at home

Guardians

Name	Telephone number where you can be reached during the day
Name	Telephone number where you can be reached during the day

<p>The child lives</p> <p><input type="checkbox"/> with two guardians</p> <p><input type="checkbox"/> with one guardian</p> <p><input type="checkbox"/> alternating residence</p> <p><input type="checkbox"/> other arrangement, please specify _____</p>	<p>Changes in the family structure</p> <p><input type="checkbox"/> no changes</p> <p><input type="checkbox"/> separated/divorced in _____</p> <p><input type="checkbox"/> joint custody</p> <p><input type="checkbox"/> sole custody</p> <p><input type="checkbox"/> new cohabitation relationship/marriage in _____</p> <p><input type="checkbox"/> other _____</p>
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Visiting / alternating residence arrangements if the guardians live separately

Does your child have siblings?

no yes, first names and years of birth

Other persons belonging to the family or same household

Child's health and wellbeing

How would you assess your child's current health? good average poor

Does your child have some long-term (physical or mental) symptom, illness or disability?

no yes, please specify _____

Care provider, and current treatments and limitations

• allergy no yes _____

• special diet no yes _____

• medication in use no yes _____

During the past year, has your child repeatedly suffered from

• tiredness or sleeping difficulties no yes _____

• timidity or tension no yes _____

• violent behaviour, aggressiveness no yes _____

• restlessness, difficulties concentrating no yes _____

• fears, anxiety no yes _____

• melancholy, isolation from others no yes _____

• bedtime or daytime wetting no yes _____

• pain under physical strain no yes _____

• other symptoms, ailments or pains no yes _____

• accidents no yes _____

Has your child ever lost consciousness while lying down or under physical strain? no yes

Does your child's family have any history of sudden deaths at the age of under 50 or hereditary or recurring illnesses? no yes, please specify _____

Health habits

Our child

• **sleeps** on school days at _____ - _____, around _____ hours.

on weekends at _____ - _____, around _____ hours.

• **engages in physical activity** each day around _____ hours (physical education classes, getting to and from school, outdoor activities, hobbies)

• **screen time** on school days _____ hours/day (mobile phone, computer, gaming consoles, TV etc.)

on weekends _____ hours/day

Does your child use the internet? yes no

Our family's eating habits

what is good _____

what should be developed _____

Our child's meals

	breakfast	school meal/lunch	afternoon snack	dinner	bedtime snack
on school days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
on weekends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Our child's diet includes

• milk or so-called plant-based milk or products made from these yes no
please specify _____

• vegetables and/or fruits yes no

• meat yes no

• fish yes no

Our child uses a vitamin D supplement daily occasionally never

daily dose _____ micrograms

How often does your child brush her/his teeth?

How does your child take care of her/his personal hygiene? (showering, changing clothes etc.)

Use of tobacco and nicotine products and intoxicants in our family

- tobacco and nicotine products no yes, _____
- alcohol no yes, _____
- drugs no yes, _____

School

How is your child's school attendance and homework going?

What are your child's strengths at school?

Is your child's learning supported? (targeted instruction, instruction given by special education needs teacher etc.)

no yes, please specify

Is your child seeing/has your child been seeing a school social worker or a school psychologist?

no yes, why? _____

How do you feel the cooperation between home and school is going?

Does your child enjoy attending school? yes I don't know no

Does your child have friends at school? yes I don't know no

Is your child being bullied at school? yes I don't know no

Has your child been involved in bullying anyone at school? yes I don't know no

Childcare arrangements for mornings and afternoons during the first year of school

Leisure time

What does your child do during her/his leisure time? (alone/together with friends/family or in hobbies)

Our child's curfew is at _____

Does your child have friends during leisure time? yes I don't know no

Do you know any of your child's friends? yes no

Is your child being bullied during leisure time? yes I don't know no

Has your child been involved in bullying anyone during leisure time? yes I don't know no

Do you know where and with whom your child spends her/his leisure time? yes no

Family

Does your family spend enough time together? yes no
How do you spend it?

Our family

- tends to give encouragement and positive feedback yes no
- shares household chores yes no
- is safe for everyone and has a generally amicable atmosphere yes no
- tends to share what has happened during the day yes no
- has agreed on rules together yes no
- eats a meal together every day yes no

How does your family solve situations where a child has broken agreed rules or is misbehaving?

Do you feel you need help in matters concerning your child's upbringing?

- no
- yes, what kind of help? _____
- we are already receiving/have received support, from whom? (e.g. a child guidance and family counselling clinic)

All worries, issues taking up resources and changes in the family affect the pupil's welfare and coping at school. In your family, is there

- long-term illnesses (physical or mental) no yes _____
- difficulties coping, exhaustion or depression no yes _____
- insecurity or violence no yes _____
- issues related to use of intoxicants or addiction no yes _____
- problems in relationships between family members no yes _____
- financial worries no yes _____
- grief or losses no yes _____
- some other current issues, please specify _____

Who supports you in making your family's daily life run smoothly if necessary?

- grandparents ex-spouse neighbours friends
 no one others

Your family's strengths

What about your child delights you?

Your wishes for the health examination

Date

Signature of the person(s) who filled out the form