

## Background information questionnaire for a health examination for the guardians of 5th grade pupils

Your child will soon have a health examination in school health care. The extensive health examination for 5th 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 after the child started school</p> <p><input type="checkbox"/> no changes</p> <p><input type="checkbox"/> separated/divorced in _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> joint custody</p> <p style="padding-left: 20px;"><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 \_\_\_\_\_

Have you noticed any changes related to puberty in your child? Please specify.

\_\_\_\_\_

\_\_\_\_\_

Have you discussed puberty with your child?

no  yes, which themes? \_\_\_\_\_

\_\_\_\_\_

## 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 on school days on weekends

• breakfast

• school meal/lunch

• afternoon snack

• dinner

• bedtime snack

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, \_\_\_\_\_

Have you talked about tobacco and nicotine products and intoxicants with your child?  yes  no

## 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

## 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 \_\_\_\_\_ on school days and at \_\_\_\_\_ on weekends.

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?

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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?

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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 \_\_\_\_\_
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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

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What about your child delights you?

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Your wishes for the health examination

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Date

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

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