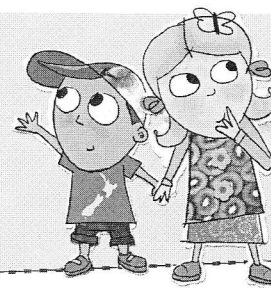


Very IMPORTANT Things About ME QUESTIONNAIRE



write
today's date
here

☐ Data entered ☐ Invoiced

Name of medical centre :

Name of person providing B4SC :

CHILD'S DETAILS

Family name

First name(s)

Also known as

Date of birth ☐ Boy ☐ Girl NHI

Home address

Ethnicity (tick all the boxes that apply)

☐ New Zealand European ☐ Samoan ☐ Cook Island Maori ☐ Chinese
☐ Maori ☐ Niuean ☐ Tongan ☐ Indian
☐ Other.....

Details of Parent/Caregiver/Guardian

Name Relationship to child:

Address:

Phone: ☐ Home ☐ Work ☐ Mobile

Tick one phone number that you would prefer to be contacted on

CONSENT



I have read the "Information for Parents and Guardians" leaflet and understand that the data will be stored on a New Zealand data base. ☐ YES ☐ NO

I understand what the B4 School Check involves and
PRINT FULL NAME OF PARENT/LEGAL GUARDIAN

YES ☐ NO ☐ I give my consent to the B4 School Check.

YES ☐ NO ☐ I give permission for data to be shared with external health and education agencies managing this programme.

Signature: Date

PARENT OR LEGAL GUARDIAN

NHI Number

For the Public Health Nurses*:

Who is your family Doctor?

What is the name of your medical centre?

CHILD HEALTH QUESTIONNAIRE

Which early childhood centre, if any, does your child attend?

Location of early childhood centre:

If your child is not enrolled in early childhood education, would you like them to be ? ☐ YES ☐ NO

If yes, do you give your permission for your contact details to be shared with the Ministry of Education so they can contact you ? ☐ YES ☐ NO

If yes, provider of the check to phone (07) 850 8880 to arrange contact.

School the child will attend at 5 years:

Do you have any other children in your care? ☐ YES ☐ NO

Does your child have any pre-existing conditions? (eg. allergies, asthma, eczema or other skin problems, heart condition, epilepsy or fits, cerebral palsy, chronic chest cough, learning problems, other conditions)

If so, do you have any concerns about these ?

Has your child spent time in hospital? ☐ YES ☐ NO

If yes, details:

Is your child on any medication? ☐ YES ☐ NO

Please list:

NHI Number

Final Questions:

Is the caregiver currently getting help from any services? ☐ YES ☐ NO

If yes, which services?
.....

It is mandatory to write a comment in the database if yes is the answer to any of the following 3 questions:

1) Does the caregiver have any concerns about toileting? ☐ YES ☐ NO

Comments:

2) Does the caregiver have any concerns about sleep? ☐ YES ☐ NO

Comments:

3) Does the caregiver have any concerns about eating? ☐ YES ☐ NO

Comments:

Does anyone in the household smoke indoors? ☐ YES ☐ NO

Mandatory to document smoking answer in B4SC database

Is there anything else about the child that the caregiver would like to talk about with the nurse?
.....

Health topics the nurse should discuss with you:

- Family relationships
- Feeding your child/nutrition
- Safety (traffic, sunsmart, water/swimming, safety belts, car seats)
- Outcome Chosen:
- Reading/the library
- Recognition of illness (when to seek medical advice)
- Preparation for School



DENTAL

Lift the Lip grade
(ie Progression of decay)

Was the child already enrolled with the dental service? ☐ YES ☐ NO

Has the child been enrolled with dental at the B4SC? ☐ YES ☐ NO

- Outcome Chosen:

**Child must be referred if
Lift the Lip grade is 2 or higher**

GROWTH

Height.....Weight.....

- Outcome Chosen:

**If BMI is ≥ 21
Child should be referred**

IMMUNISATIONS

☐ 6 weeks ☐ 3 months ☐ 5 months ☐ 15 months ☐ 4 years

Date 4 year old immunisations were given:

- Outcome Chosen:

PARENTAL EVALUATION OF DEVELOPMENTAL STATUS

PEDS RESPONSE FORM

1 Please list any concerns about your child's learning, development and behavior.

☐

2 Do you have any concerns about how your child talks and makes speech sounds.

Circle one: YES NO A LITTLE COMMENTS:

☐

3 Do you have any concerns about how your child understands what you say.

Circle one: YES NO A LITTLE COMMENTS:

☐

4 Do you have any concerns about how your child uses his or her hands and fingers to do things.

Circle one: YES NO A LITTLE COMMENTS:

☐

5 Do you have any concerns about how your child uses his or her arms and legs.

Circle one: YES NO A LITTLE COMMENTS:

☐

6 Do you have any concerns about how your child behaves.

Circle one: YES NO A LITTLE COMMENTS:

☐

7 Do you have any concerns about how your child gets along with others.

Circle one: YES NO A LITTLE COMMENTS:

☐

8 Do you have any concerns about how your child is learning to do things for him/herself.

Circle one: YES NO A LITTLE COMMENTS:

☐

9 Do you have any concerns about how your child is learning preschool or school skills.

Circle one: YES NO A LITTLE COMMENTS:

☐

10 Please list any other concerns.

☐


WHAT NOW ???

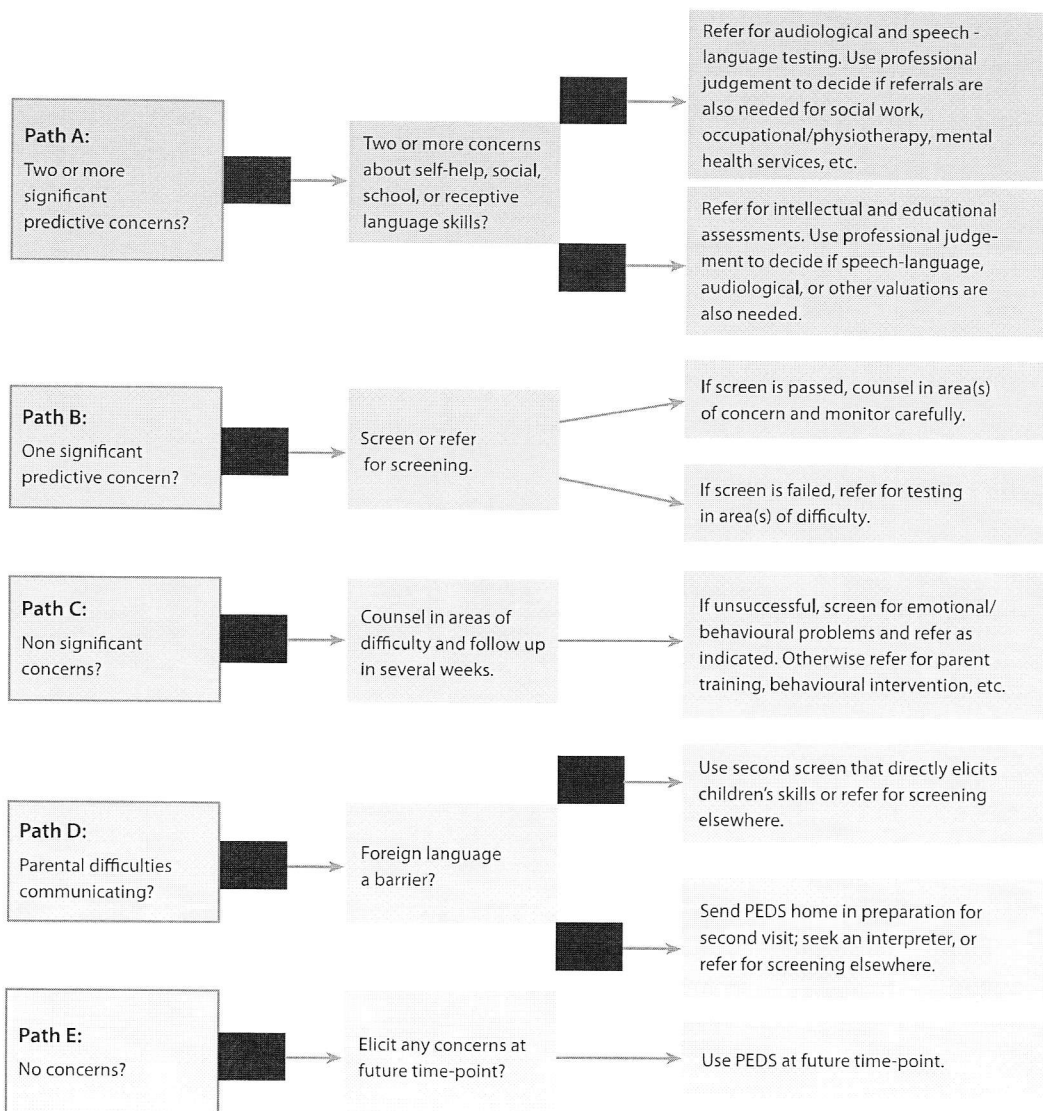
NHI Number

If the number in the shaded box is 2 or more, follow **Path A**.
If the number shown is exactly 1, follow **Path B**.

Total
Shaded Score

If the number in the unshaded box is 1 or more, follow **Path C**.
If the number shown is 0, consider **Path D** if relevant. Otherwise follow **Path E**.

Total
Unshaded Score



WHAT'S THE PLAN?



*** If pathway A is indicated, child should be referred**

- Outcome Chosen:

NB: If you require advice or want to refer for speech and language issues and/or behaviour issues (ie Special Education) phone 07) 850 8880.

NHI Number

STRENGTHS AND DIFFICULTIES QUESTIONNAIRE

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last 6 months. We are looking for **EXTREME** behaviour.

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of head aches, stomach aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children, for example, toys, treats, pencils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, prefers to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often argumentative with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can stop and think things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can be spiteful to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees work through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?



Please turn over- there are a few more questions over the page

Overall, do you think your child has difficulties in one or more of the following areas:

emotions, concentration, behavior or being able to get on with other people?

NO	YES Minor difficulties	YES Definite difficulties	YES Severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your child's everyday life in the following areas:

	Not at all	Only a little	Quite a lot	A great deal
Home life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*** If SDQ score is equal or greater than 17, child should be referred.**

- Outcome Chosen: