

CHILDRENS QUESTIONNAIRE

Children aged under 16

Ethnicity: White / Black / Mixed Race / Asian / Arabic / Indian / Caribbean / African / Chinese / European / British / English / Irish / Scottish / Welsh / Other _____	
Language: Please state your main first spoken language: _____	
Preferred Language: _____	Religion: _____
Country of Birth: _____	Date first entered UK: ____/____/____ (If not born in UK)

CHILD'S MEDICAL HISTORY

Has your child had:	<input type="checkbox"/>	MEASLES	<input type="checkbox"/>	MUMPS
<input type="checkbox"/> GERMAN MEASLES	<input type="checkbox"/>	WHOOPING COUGH	<input type="checkbox"/>	ASTHMA
<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/>	MENINGITIS	<input type="checkbox"/>	FITS
<input type="checkbox"/>	OTHER SERIOUS ILLNESS - Please give details _____			
<input type="checkbox"/>	ANY SERIOUS ACCIDENTS - Please give details _____			

Previous Medication: _____
Allergies: _____

Is there any family history of Asthma / Fits / Epilepsy in the child's parents / brothers / sisters? Yes / No

If Yes, please give details: _____

IMMUNISATIONS

Please tick if they have been given & by whom. (Please give dates if possible)

VACCINATION & DATE	G.P.	OTHER
FIRST TRIPLE & POLIO		
FIRST PNEUMOCOCCAL		
ROTAVIRUS		
SECOND TRIPLE & POLIO		
FIRST MENINGOCOCCAL		
THIRD TRIPLE & POLIO		
SECOND PNEUMOCOCCAL		
SECOND MENINGOCOCCAL		
MMR (Measles, Mumps & Rubella)		
PRE-SCHOOL BOOSTER		
MMR BOOSTER		
RUBELLA		
ANY OTHER:		

Parent / Guardian Signature _____