Other Information

For more information about child vision screening, please visit:
Vision Defects - UK National Screening Committee (UK NSC) - GOV.UK (view- health-screening-recommendations.service.gov.uk)

If you want to opt your child out of the Reception year vision screening please email the Young Greenwich screening team on: **oxl-tr.ncmp@nhs.net**

If you would like further health and wellbeing advice or information for you and your family, please see our Parent Page on the website for drop in details: www.young-greenwich.org.uk

Or contact us via:
Email: Oxl-tr.younggreenwichhealth@nhs.net
Telephone: 0208 317 6319

Thank you for sharing your child's details with us.

If you agree that any relevant medical information can be shared with the school, please tick the box: ☐

Parent / Carer Signature:

Date:

Triaged by:

Date:

For details on how we look after your information, how we process it and who we share it with see our Privacy Notice at www.oxleas.nhs.uk/gdpr. Please let us know if you require a paper copy.

Young Greenwich School Nursing Service (Autumn 2021)

RECEPTION AND NEW TO COUNTRY / BOROUGH CHILDREN ONLY

Dear Parent/Carer,

The Young Greenwich school nursing team is committed to the health improvement of children and young people of school age by promoting positive attitudes towards good health and ensuring they have access to a dedicated and responsive service.

A member of the team will complete the vision screening in Reception year (Spring Term) and the National Child Measurement Programme (height and weight) in Reception and Year 6 (Autumn Term).

If your child has an identified health need, the team will contact you, via text, email, or telephone, to discuss your child's management in school.

PLEASE COMPLETE IN BLOCK CAPITALS and return to school

School:	Class:
Surname (Child):	First name:
Date of birth:	Known as: (if different from above)
Gender:	First Language:
Ethnicity:	Previous School: (out of borough / country only):
Home Address:	Postcode:

Sibling Details

Name:	Known as:	D.O.B: dd/mm/yy	School:

Parent/Carer Details

1) Parent/Carer Name:
Relationship to child:
First language:
Interpreter required? Yes /No
Do you hold Parental Responsibility? Yes /No

2) Parent/Carer Name:
Relationship to child:
First language:
Interpreter required? Yes /No
Do you hold Parental Responsibility? Yes /No
Email and Telephone contact number of main Parent/Carer:

GP Information

Is your child registered with a GP? Yes/No /Don't know

If YES please name GP surgery:

Does your child regularly attend the GP, have regular treatments or medication? If YES, please give details:

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Other Health Information Required

Is your child registered with a Dentist? Yes/ No/Don't know

Does your child wear glasses? Yes /No
If yes, are they under the local Optician or Hospital clinic (please circle)

Does your child attend hospital or clinics such as CAMHS, Community Doctor, Speech and Language, Audiology, Occupational Therapy or Physiotherapy?
Please give details.

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Does your child have any of the following? (Please tick as appropriate)

Epilepsy /Fits /Convulsions Asthma

Diabetes – Type 1 / Type 2

Thalassemia / Sickle Cell Anaemia

Severe allergies that require emergency medication:
(please name medication and allergy)

Does your child had any other long term medical needs? Yes / No
Please give more detail:

Does your child have an EHCP? Yes / No
(Education Health Care Plan)

Vaccinations

Is your child up to date with the Childhood Vaccination Schedule including Pre School Booster and MMR? Please circle:
Yes / No / Don't know / Declined

If you are not sure you can search online for vaccination schedule, or visit: www.nhs.uk/conditions/vaccinations.

If your child has not had any of the named immunisations, please take them to the GP or Practice Nurse as soon as possible.