

Questionnaire for the school entry health examination

The school doctor requires the information from questions 1-13 for the medical/developmental assessment in accordance with Section 11 of the Regulation for Public Primary Schools in Rhineland-Palatinate. The information serves as the basis for the interview and for determining the current level of development of your child. We request that you answer all these questions. Any uncertainties about individual questions can be clarified during the interview.



1. Family information		Completed on:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">Day</td> <td style="text-align: center; font-size: 8px;">Month</td> <td colspan="2" style="text-align: center; font-size: 8px;">Year</td> <td></td> </tr> </table>						Day	Month	Year		
Day	Month	Year											
	Child	Parent/Guardian 1 (e.g., father/mother)	Parent/Guardian 2 (e.g., father/mother)										
Family name	_____	_____	_____										
First name	_____	_____	_____										
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/>										
Date of birth	<table border="1" style="display: inline-table; border-collapse: collapse; font-size: 8px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 6px;">Day</td> <td style="text-align: center; font-size: 6px;">Month</td> <td colspan="2" style="text-align: center; font-size: 6px;">Year</td> <td></td> </tr> </table>						Day	Month	Year			Child's country of birth _____	
Day	Month	Year											
Address	_____												

<p>2. How has your child been cared for? Which childcare facilities has your child attended?</p> <p>a) My child was cared for exclusively within the family until the age of ____ years and ____ months.</p> <p>b) My child then attended the following childcare facilities: (Multiple answers possible)</p> <p>Day nursery..... <input type="checkbox"/> Preschool/nursery school..... <input type="checkbox"/> Preschool for children with special needs..... <input type="checkbox"/></p> <p>Childminder/home daycare. <input type="checkbox"/> Integrated nursery school..... <input type="checkbox"/> No facility..... <input type="checkbox"/></p> <p>c) My child currently attends the following childcare facility:</p> <p>Day nursery..... <input type="checkbox"/> Preschool/nursery school..... <input type="checkbox"/> Preschool for children with special needs..... <input type="checkbox"/></p> <p>Childminder/home daycare. <input type="checkbox"/> Integrated nursery school..... <input type="checkbox"/> No facility..... <input type="checkbox"/></p>

<p>3. Which infectious diseases has your child had? (Multiple answers possible)</p> <p>Chickenpox (varicella)..... <input type="checkbox"/> Mumps..... <input type="checkbox"/> Salmonella..... <input type="checkbox"/></p> <p>Scarlet fever..... <input type="checkbox"/> Rubella..... <input type="checkbox"/> Lyme disease..... <input type="checkbox"/></p> <p>Slapped cheek syndrome (fifth disease)..... <input type="checkbox"/> Whooping cough (pertussis)..... <input type="checkbox"/> Meningitis..... <input type="checkbox"/></p> <p>Measles..... <input type="checkbox"/> Hepatitis B..... <input type="checkbox"/> Rotavirus..... <input type="checkbox"/></p> <p>Other..... <input type="checkbox"/> Covid-19..... <input type="checkbox"/> None..... <input type="checkbox"/></p> <p>If other, please specify _____</p>

<p>4. Which acute illnesses have occurred in the past 12 months? (Multiple answers possible)</p> <p>Bronchitis..... <input type="checkbox"/> Bladder/urinary tract infections <input type="checkbox"/> Bout of pseudo-croup..... <input type="checkbox"/></p> <p>Sore throat/tonsillitis..... <input type="checkbox"/> Pneumonia..... <input type="checkbox"/> Seizure..... <input type="checkbox"/></p> <p>Middle ear infection..... <input type="checkbox"/> Febrile convulsions..... <input type="checkbox"/> Frequent infections..... <input type="checkbox"/></p> <p>Gastroenteritis..... <input type="checkbox"/></p> <p>Other..... <input type="checkbox"/> None..... <input type="checkbox"/></p> <p>If other, please specify _____</p>

5. Has your child ever had the following illnesses or impairments diagnosed by a doctor? (Multiple answers possible) Please bring any supporting documentation with you.

- | | | | | | |
|---------------------------|--------------------------|---------------------------------------|--------------------------|------------------------------|--------------------------|
| Allergies..... | <input type="checkbox"/> | Polyps (adenoids)..... | <input type="checkbox"/> | Seizures (epilepsy)..... | <input type="checkbox"/> |
| Neurodermatitis..... | <input type="checkbox"/> | Spinal disorders..... | <input type="checkbox"/> | Tumour/cancer..... | <input type="checkbox"/> |
| Chronic bronchitis..... | <input type="checkbox"/> | Thyroid disease..... | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> |
| Bronchial asthma..... | <input type="checkbox"/> | Heart defects/diseases..... | <input type="checkbox"/> | Autism..... | <input type="checkbox"/> |
| Hay fever..... | <input type="checkbox"/> | Diabetes mellitus..... | <input type="checkbox"/> | Congenital impairment..... | <input type="checkbox"/> |
| Food allergies..... | <input type="checkbox"/> | Chronic urinary tract infections..... | <input type="checkbox"/> | Physical impairment..... | <input type="checkbox"/> |
| Allergic skin rashes..... | <input type="checkbox"/> | Attention deficit syndrome..... | <input type="checkbox"/> | Intellectual impairment..... | <input type="checkbox"/> |
| Other..... | <input type="checkbox"/> | Mental illnesses..... | <input type="checkbox"/> | None..... | <input type="checkbox"/> |

If other, please specify _____

6. Has your child had the following symptoms or impairments in the past 12 months? (Multiple answers possible)

- | | | | | | |
|-----------------------------|--------------------------|-------------------------------|--------------------------|--|--------------------------|
| Vision impairments..... | <input type="checkbox"/> | Parasitic worm infection..... | <input type="checkbox"/> | Food intolerances..... | <input type="checkbox"/> |
| Hearing impairments..... | <input type="checkbox"/> | Overweight..... | <input type="checkbox"/> | Motor restlessness / hyperactivity..... | <input type="checkbox"/> |
| Speech problems..... | <input type="checkbox"/> | Underweight..... | <input type="checkbox"/> | Aggressiveness..... | <input type="checkbox"/> |
| Developmental delays..... | <input type="checkbox"/> | Frequent headaches..... | <input type="checkbox"/> | Sleep disturbances..... | <input type="checkbox"/> |
| Concentration disorder..... | <input type="checkbox"/> | Frequent stomach aches..... | <input type="checkbox"/> | Frequent snoring (without infection)... | <input type="checkbox"/> |
| Bed wetting..... | <input type="checkbox"/> | Frequent leg pain..... | <input type="checkbox"/> | Oral respiration / obstructed nasal respiration..... | <input type="checkbox"/> |
| Faecal incontinence..... | <input type="checkbox"/> | Anxiety..... | <input type="checkbox"/> | Pronounced daytime sleepiness..... | <input type="checkbox"/> |
| Other..... | <input type="checkbox"/> | | | None..... | <input type="checkbox"/> |

If other, please specify _____

7. Which doctors or therapists has your child visited in the past 12 months? (Multiple answers possible)

- | | | | | | |
|---------------------------|--------------------------|----------------------------|--------------------------|--|--------------------------|
| Paediatrician..... | <input type="checkbox"/> | Ophthalmologist..... | <input type="checkbox"/> | Alternative practitioner..... | <input type="checkbox"/> |
| General practitioner..... | <input type="checkbox"/> | ENT doctor..... | <input type="checkbox"/> | Child and adolescent psychiatrist..... | <input type="checkbox"/> |
| Dentist | <input type="checkbox"/> | Dermatologist | <input type="checkbox"/> | Psychologist/Psychotherapist..... | <input type="checkbox"/> |
| Orthodontist..... | <input type="checkbox"/> | Urologist..... | <input type="checkbox"/> | Surgeon/orthopaedist..... | <input type="checkbox"/> |
| Other..... | <input type="checkbox"/> | Paediatric cardiologist... | <input type="checkbox"/> | None | <input type="checkbox"/> |

If other, please specify _____

8. Has your child ever had the following examinations or treatments? (Multiple answers possible)

- | | | |
|---|--------------------------|--|
| Development diagnostics..... | <input type="checkbox"/> | Detailed information (e.g. outpatient surgery: polyps) |
| Stay at a rehabilitation or cure centre | <input type="checkbox"/> | _____ |
| Allergy test..... | <input type="checkbox"/> | _____ |
| Outpatient surgery..... | <input type="checkbox"/> | _____ |
| Inpatient hospital treatment..... | <input type="checkbox"/> | _____ |
| No examinations/treatments..... | <input type="checkbox"/> | |

9. Which treatments or support has your child received? (Multiple answers possible)

- | | | | | | |
|-----------------------------------|--------------------------|------------------------------|--------------------------|--------------------------------|--------------------------|
| Speech therapy / logopaedics..... | <input type="checkbox"/> | Early support..... | <input type="checkbox"/> | Remedial instruction..... | <input type="checkbox"/> |
| Occupational therapy..... | <input type="checkbox"/> | Integration support..... | <input type="checkbox"/> | Psychotherapy..... | <input type="checkbox"/> |
| Physical therapy..... | <input type="checkbox"/> | Educational counselling..... | <input type="checkbox"/> | Psychological counselling..... | <input type="checkbox"/> |
| Orthodontic treatment..... | <input type="checkbox"/> | | | Family assistance (SPFH)..... | <input type="checkbox"/> |
| Other..... | <input type="checkbox"/> | | | None..... | <input type="checkbox"/> |

If other, please specify _____

What were the causes/reasons for the treatment and/or support? _____

Duration of treatment: _____

10. Has your child ever had accidents or poisonings that required medical treatment? (Multiple answers possible)

- Accident at home..... Traffic accident..... Poisoning.....
 Accident in a childcare facility (e.g., nursery school)..... Accident in another place (e.g., club, gymnasium)..... None.....

11. Has your child taken medication in the past 12 months?

Yes..... No.....

If yes, due to:	Regularly	As needed	Name of the medication
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bronchial asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy (seizures)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hyperactivity.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other chronic illnesses.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does your child need to take any medications in school? Regularly..... As needed..... No.....

Does your child need assistance taking medication in school? Yes... No.... No medication is taken in school

12. Would you like to give us additional information about your child?

13. Who answered the questionnaire? (Multiple answers possible)

- Parent/guardian 1..... Grandmother.... Foster mother..... Sibling of the child.....
 Parent/guardian 2..... Grandfather..... Foster father..... Other person.....

Providing a response to questions 14-23 is voluntary.

These questions are used primarily for health reporting and support research on children's health. The school entry health examination and subsequent examinations or statements do not use this information. In case of doubt, you can also leave individual questions unanswered. This of course will not result in any disadvantages for you or your child.

14. How long was your child breastfed?		
a) Not breastfed.....	<input type="checkbox"/> Less than 1 month.....	<input type="checkbox"/> 1-3 months.....
4-6 months.....	<input type="checkbox"/> More than 6 months.....	<input type="checkbox"/> Unknown.....
b) From ____ months of age, supplemental food was given (solid food and/or formula).		<input type="checkbox"/> Unknown.....
15. With whom does the child live primarily? (Please tick only one box here)		
With the biological parents.....	<input type="checkbox"/> With foster parents / adoptive parents.....	<input type="checkbox"/>
With Parent/Guardian 1.....	<input type="checkbox"/> With other family members.....	<input type="checkbox"/>
With Parent/Guardian 2.....	<input type="checkbox"/> With other persons.....	<input type="checkbox"/>
In a stepfamily or patchwork family.....	<input type="checkbox"/> In an orphanage.....	<input type="checkbox"/>
In a joint custody model (equally frequent with parents living in separate households).....		<input type="checkbox"/>
16. How many children live in your household? (Including the child entering school)		
1 child	<input type="checkbox"/> 2 children	<input type="checkbox"/> 3 children
<input type="checkbox"/> 4 children	<input type="checkbox"/> More than 4 children	<input type="checkbox"/> ____ children.
17. Which languages are spoken in your home? (Multiple answers possible)		
German.....	<input type="checkbox"/> Other languages.....	<input type="checkbox"/> Which? _____
18. In which country were you born? (Please answer for both parents/guardians)		
Parent/Guardian 1	In Germany....	<input type="checkbox"/> In another country.....
		<input type="checkbox"/> In which? _____
Parent/Guardian 2	In Germany....	<input type="checkbox"/> In another country.....
		<input type="checkbox"/> In which? _____
19. What is your nationality? (Please answer for the child and both parents/guardians)		
Child	German	<input type="checkbox"/> Other / additional nationality
		<input type="checkbox"/> Which? _____
Parent/Guardian 1	German	<input type="checkbox"/> Other / additional nationality
		<input type="checkbox"/> Which? _____
Parent/Guardian 2	German	<input type="checkbox"/> Other / additional nationality
		<input type="checkbox"/> Which? _____
20. Does anyone smoke in your household?		
Never.....	<input type="checkbox"/> Occasionally.....	<input type="checkbox"/> Frequently.....
		<input type="checkbox"/>
21. What is your highest level of secondary education? (Please answer for both parents/guardians)		
	Parent/Guardian 1	Parent/Guardian 2
Lower secondary education (Hauptschule/Volksschule).....	<input type="checkbox"/>	<input type="checkbox"/>
Upper secondary education (Realschule: Mittlere Reife).....	<input type="checkbox"/>	<input type="checkbox"/>
Upper secondary education for admission to a university of applied sciences (Fachoberschule).....	<input type="checkbox"/>	<input type="checkbox"/>
General university entrance qualification (Abitur).....	<input type="checkbox"/>	<input type="checkbox"/>
Other school-leaving qualification.....	<input type="checkbox"/>	<input type="checkbox"/>
Still attending school.....	<input type="checkbox"/>	<input type="checkbox"/>
Ended school without a school-leaving qualification.....	<input type="checkbox"/>	<input type="checkbox"/>
None of the above.....	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you completed post-secondary education? If yes, what kind?		
(Please mark only the highest level completed.)	Parent/Guardian 1	Parent/Guardian 2
Apprenticeship (professional training in a business).....	<input type="checkbox"/>	<input type="checkbox"/>
Vocational school, trade school (professional training in a school).....	<input type="checkbox"/>	<input type="checkbox"/>
Technical school (e.g., master tradesmen school, vocational or technical academy).....	<input type="checkbox"/>	<input type="checkbox"/>
University of applied sciences, school of engineering.....	<input type="checkbox"/>	<input type="checkbox"/>
University, college.....	<input type="checkbox"/>	<input type="checkbox"/>
Other degree.....	<input type="checkbox"/>	<input type="checkbox"/>
Still attending post-secondary education.....	<input type="checkbox"/>	<input type="checkbox"/>
No degree.....	<input type="checkbox"/>	<input type="checkbox"/>
None of the above.....	<input type="checkbox"/>	<input type="checkbox"/>
23. To what extent are you currently employed?		
	Parent/Guardian 1	Parent/Guardian 2
Employed full-time.....	<input type="checkbox"/>	<input type="checkbox"/>
Partially employed (e.g. part-time employment, hourly employment)....	<input type="checkbox"/>	<input type="checkbox"/>
Currently unemployed.....	<input type="checkbox"/>	<input type="checkbox"/>