ACT Government | Canberra Health Services

INFORMATION FOR THE KINDERGARTEN HEALTH CHECK 2023

Dear Parent/Guardian

Canberra Health Services (CHS) is pleased to offer the 2023 Kindergarten Health Check (KHC) to your child in their first year of primary school. The aim of the program is to promote child health and wellbeing and help with the identification of children with potential health problems that may affect their ability to learn.

The KHC program includes:

- A health check provided by School Health Registered Nurses at your child's school
- A questionnaire (enclosed with this letter) answered by parents/guardians

The health check:

The School Health Registered Nurses will visit your child's school during 2023, and with your consent, will conduct the following health checks:

Vision check
Distance vision and eye movements will be checked, using an eye chart and a small light directed briefly into your child's eyes

Hearing check
Headphones will be placed on your child's ears to check their response to sounds

Height, Weight and Body Mass Index
Height and weight will be measured, without shoes or jumper (your child will not be informed of the results)

Once the health check has been completed, the results will be available for you to see in the **My Digital Health Record.** If you wish to have the results posted to you instead, please contact the School Health Team. Phone: 5124 1585.

To register for access to your child's My Digital Heath Record, scan this QR code or visit dhr.act.gov.au

If your child would benefit from further assessment or referral to other services, information will be provided.

The hearing and vision results are only provided to your child's teacher if you give consent.

The GP or Medical Practice you nominate will also receive the results of the health check, if you give

your consent.

The questionnaire:

The questionnaire asks you about your child's physical health, food choices, how much they move through the day, their development, behaviour and emotional health, and enables the school nurse and your child's GP to understand any concerns you may have about your child's health, and to provide appropriate advice and referral. Included is a section on Adverse Childhood Experiences (ACEs). ACEs is a term used to describe stressful events or circumstances that children may experience throughout childhood.

All families at some time experience upsetting events such as grief, loss, parent separation or divorce and even violence. These experiences may impact children's behaviours, learning and interactions with friends. While ACEs can occur in children and young people, the physical and mental health effects may continue into adult life. Answering the ACEs questions will assist us in connecting your child to appropriate support services if needed.

Please Turn Over

For more information about ACEs, please visit Emerging Minds ACEs resources at emergingminds.com.au/.
The results of the questionnaires will be posted to your nominated GP if you give your permission to do so. The GP will be able to discuss follow-up or further assessment, if needed.

You may complete the questionnaire some months before the health check is provided at school. If you have health or development concerns about your child, please see your GP and don't wait for the health check to be completed first.

If your child does not already attend a GP or Medical Practice with which you have an established relationship, we encourage you to find a practice that you feel comfortable with, and who can assist with the health care of your child.

Visit ACT Health's Find a Health Service: findahealthservice.act.gov.au/. Click on the **General Practitioner** link to search by suburb or region.

Privacy Information:

The KHC collects personal and health information about your child that is essential to provide services to your child under the program. For information regarding privacy in relation to ACT Government websites and on-line facilities, including the Digital Health Record, please visit: health.act.gov.au/privacy

Use and release of personal and health information:

Identifiable information about your child received through the KHC will not be released without your consent except when there is a concern for the safety of a child. All CHS and ACT Health staff and GPs are mandated by legislation and obligated to notify concerns regarding the safety of children to the appropriate agency/agencies.

We are committed to improving health services and provide for the needs of the Canberra community. Information collected under the KHC program is necessary to provide services to your child under the KHC program. It is also used by ACT Health and CHS for research and statistical reasons, to monitor child health and wellbeing in the ACT, and to help in the planning of health services.

Identifying information about you and your child, are removed prior to analysis of collected data, and the information is stored in a secure ACT Health database. Researchers, usually in health and education, who are granted approval by the ACT Health Human Research Ethics Committee may apply for access to this data. You may be invited to participate in future childhood health research as approved by the ACT Health and the ACT Education Directorates.

If you do not wish your child's information to be used for research, but would still like your child's vision, hearing and growth checked, then please contact the **Kindergarten Health Check Research Nurse on 5124 4949** or email: KindyHealthAUGP@act.gov.au

If you have any concerns or complaints about the conduct of this research, and are not comfortable discussing this with research staff, you may contact the Research Ethics and Governance Office secretariat who is nominated to receive complaints about projects, on 5124 7968 or ethics@act.gov.au

School Health Team
Division of Women, Youth & Children
Community Health Programs
Canberra Health Services
Phone: 5124 1585

Accessibility	
If you have difficulty reading a standard printed document and would like an alternative format, please phone 13 22 81.	
	If English is not your first language and you need the Translating and Interpreting Service (TIS), please call 13 14 50.
For further accessibility information, visit: www.health.act.gov.au/accessibility	
www.health.act.gov.au | Phone: 132281 | Publication No. 2023	

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OFFICE USE ONLY

URN: _____

Family name: _____

Given names: _____

DOB: _____ *Sex:* _____

KINDERGARTEN HEALTH CHECK CONSENT AND QUESTIONNAIRE

Year 2023

Child's family name: _____ DOB: _____

Child's given name/s: _____ Sex: ☐ Male ☐ Female ☐ Other

Other, please specify: _____

School: _____ Roll group / class: _____

Home address: _____

Suburb / town: _____ Postcode: _____

Postal address (if different to home address): _____

Suburb / town: _____ Postcode: _____

Country of birth: _____

Is your child of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

☐ Yes, both Aboriginal and Torres Strait Islander ☐ Declined to answer

Does your child have a General Practitioner (GP) or Practice? *(That your child is registered at, and has attended.)* ☐ Yes ☐ No

Name of GP: _____ Practice name: _____

Address: _____

Suburb: _____ Postcode: _____ Phone: _____

CONSENT FOR HEALTH CHECK

- I/we have read and understood the Kindergarten Health Check information and I/we consent to the health check as described on the information sheet. ☐ Yes ☐ No
- I/we consent to the School Health Nurse alerting my child's teacher to concerns relating to hearing and vision only. ☐ Yes ☐ No
- I/we give consent for my/our child's results to be sent to the GP nominated above. ☐ Yes ☐ No
- I/we have legal parental responsibility of the child as: ☐ Parent/s ☐ Legal guardians/s

_____ _____ ___/___/2023

Parent signature 1 / Legal Guardian signature 1 | Please print name clearly in BLOCK LETTERS | Date

_____ _____ ___/___/2023

Parent signature 2 / Legal Guardian signature 2 | Please print name clearly in BLOCK LETTERS | Date

Note: Only the person who signs this form is legally able to receive correspondence or discuss results relating to this form or the health check. Both parents need to sign if both wish to receive results or make inquiries.

Parent / Guardian Contact Details

Best contact numbers during business hours: _____

_____

These questions ask you about your child's vision and hearing. Please tick ✓ the required boxes.

VISION

1. Do you have any concerns about your child's vision? ☐ Yes ☐ No

   If yes, please describe: _____

2. Has your child been prescribed glasses? ☐ Yes ☐ No

   If yes, when should they be worn? (e.g. when reading): _____

3. Has your child ever received, or are they receiving medical care for their eyes or vision? ☐ Yes ☐ No

   If yes, please describe: _____

4. Is your child currently under the care of an optometrist or eye specialist? ☐ Yes ☐ No

HEARING

1. Do you have any concerns about your child's hearing or airways? ☐ Yes ☐ No

   If yes, please describe: _____

2. Has your child had any of the following? Tick all that apply.

   Repeated ear infections ☐ Yes ☐ No

   Discharging ears ☐ Yes ☐ No

   Hearing Loss ☐ Yes ☐ No

   Grommets ☐ Yes ☐ No If yes, when were these inserted? _____

   Snoring ☐ Yes ☐ No

3. Has your child ever received or are they receiving medical care for their ears, hearing or airways?

   ☐ Yes ☐ No

   If yes, please describe: _____

4. Is your child currently under the care of an audiologist/ hearing specialist? ☐ Yes ☐ No

Would you like information on any of the following? Tick all that apply.

Wetting pants ☐ Yes ☐ No

Wetting the bed ☐ Yes ☐ No

Soiling pants ☐ Yes ☐ No

This completes the questions relating to the health check conducted by the School Health Nurses.

Please continue answering the questions about your child's development on following pages.

DO NOT WRITE IN THIS BINDING MARGIN

37625(0123)

ACT Government | ACT Health

KINDERGARTEN HEALTH CHECK QUESTIONNAIRE

Year 2023

PLEASE COMPLETE CHILD'S NAME BELOW

Family name: _____

Given names: _____

These questions ask you about asthma, eczema and hay fever.

RESPIRATORY SYMPTOMS

1. Has your child ever had wheezing or whistling in the chest? ☐ Yes ☐ No
2. Has your child ever had asthma? ☐ Yes ☐ No
3. In the last 12 months has your child experienced any of the following respiratory symptoms?
   - Wheezing or whistling in the chest ☐ Yes ☐ No
   - A dry cough at night not associated with a cold or chest infection ☐ Yes ☐ No
   - Wheezing with coughs or colds ☐ Yes ☐ No
   - Shortness of breath when exercising or playing games or participating in sports ☐ Yes ☐ No
4. In the last 12 months how often, *on average*, have the following respiratory symptoms been present?

Please tick one box on EACH line

Wheeze or whistle in the chest	☐ Never	☐ Less than 1 day / wk	☐ 1 – 3 days / wk	☐ 4 or more days / wk
Night cough or night wheeze	☐ Never	☐ Less than 1 night / wk	☐ 1 – 3 nights / wk	☐ 4 or more nights / wk
Shortness of breath (when exercising or playing)	☐ Never	☐ Less than 1 day / wk	☐ 1 – 3 days / wk	☐ 4 or more days / wk

ECZEMA

5. Has your child ever had an itchy rash that was coming and going for at least 6 months? ☐ Yes ☐ No
6. Has the itchy rash ever affected the following places? ☐ Yes ☐ No
   (the fold of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck, ears or eyes)
7. Has your child ever had eczema? ☐ Yes ☐ No

HAY FEVER

8. In the past 12 months has your child had a problem with sneezing, or a runny or blocked nose when he / she did not have a cold or the flu? ☐ Yes ☐ No
9. In the past 12 months has this nose problem been accompanied by itchy / watery eyes? ☐ Yes ☐ No
10. Has your child ever had hay fever? ☐ Yes ☐ No
11. Do any close members of the family have any of the following conditions?
    - Asthma ☐ Yes ☐ No
    - Eczema ☐ Yes ☐ No
    - Hay fever ☐ Yes ☐ No

Adapted from The International Study of Asthma and Allergies in Childhood (ISAAC): Core questionnaire

These questions ask about your child's food intake and physical activity.

WEIGHT PERCEPTION

1. How would you describe your child's weight?

- ☐ Underweight
- ☐ Healthy weight
- ☐ Overweight
- ☐ Obese
- ☐ Don't know

2. Do you have any concerns about your child's weight? ☐ Yes ☐ No

3. Do you have any concerns about your child's height? ☐ Yes ☐ No

Comments: _____

DIET

The following questions are about the food your child eats.

4. How many serves of vegetables does your child usually eat each day?
(1 serve = ½ cup cooked vegetables, or ½ medium potato, or 1 medium tomato, or 1 cup salad vegetables)

- ___ serves per day *(write number of serves) OR*
- ___ serves per week *(write number of serves)*
- ☐ my child doesn't eat vegetables
- ☐ don't know

5. How many serves of fruit does your child usually eat each day?
(1 serve = 1 medium piece, or 2 small pieces of fruit, or 1 cup of diced pieces with no added sugar, or 30 grams of dried fruit such as 4 dried apricots or 1½ tablespoons sultanas)

- ___ serves per day *(write number of serves) OR*
- ___ serves per week *(write number of serves)*
- ☐ my child doesn't eat fruit
- ☐ don't know

6. Do you have any concerns about your child's eating habits? ☐ Yes ☐ No

Comments: _____

PHYSICAL ACTIVITY

The following questions are about your child's physical activity. Physical activity is any activity that increases your heart rate and makes you get out of breath some of the time.

Physical activity can include energetic playing with friends, walking to school and nearly all sports. E.g. running, biking, trampolining, dancing, swimming, football, walking the dog.

7. Over the **past 7 days**, on how many days was your child physically active for a total of at least 60 minutes per day? Please tick one box

Number of days	0	1	2	3	4	5	6	7
	☐	☐	☐	☐	☐	☐	☐	☐

8. Over a **typical week** on how many days is your child physically active for a total of at least 60 minutes per day?
Please tick one box

Number of days	0	1	2	3	4	5	6	7
	☐	☐	☐	☐	☐	☐	☐	☐

Adapted from the Australian General Health and ACTPANS surveys

These questions ask you about TV use and screen time.

SCREEN TIME

1. How many *days* during the **school week** does your child usually watch TV, videos or DVDs at home?
   Please tick one box

Number of days	0	1	2	3	4	5
	☐	☐	☐	☐	☐	☐

2. On these days, about how many ***hours a day*** does your child usually watch TV videos or DVDs at home?

   _____ hours per day

3. How many *days* during the **school week** does your child use a computer, tablet or mobile phone to play games, surf the internet or other screen-based activities (not including school-related work)?
   Please tick one box

Number of days	0	1	2	3	4	5
	☐	☐	☐	☐	☐	☐

4. On these days, about how many ***hours a day*** does your child usually use a computer, tablet or mobile phone to play games, surf the internet or other screen-based activities (not including school-related work)?

   _____ hours per day

5. How many *days* **on the weekend** does your child usually watch TV, videos or DVDs at home?
   Please tick one box

Number of days	0	1	2
	☐	☐	☐

6. On these days, about how many ***hours a day*** does your child usually watch TV, videos or DVDs at home?

   _____ hours per day

7. How many *days* **on the weekend** does your child use a computer, tablet or mobile phone to play games, surf the internet or other screen-based activities (not including school-related work)?

Number of days	0	1	2
	☐	☐	☐

8. On these days, how many ***hours a day*** does your child usually use a computer, tablet or mobile phone to play games, surf the internet or other screen-based activities (not including school-related work)?

   _____ hours per day

Adapted from the Australian General Health and ACTPANS surveys

These questions ask you about your child's developm

PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)

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

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

☐ No ☐ Yes ☐ A little Comments:

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

☐ No ☐ Yes ☐ A little Comments:

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

☐ No ☐ Yes ☐ A little Comments:

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

☐ No ☐ Yes ☐ A little Comments:

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

☐ No ☐ Yes ☐ A little Comments:

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

☐ No ☐ Yes ☐ A little Comments:

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

☐ No ☐ Yes ☐ A little Comments:

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

☐ No ☐ Yes ☐ A little Comments:

10. Please list any other concerns.

Strengths and Difficulties Questionnaire

P or T 4-10

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 the child's behaviour over the last six months or this school year.

Child's name ..... Male/Female

Date of birth.....

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

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

These questions ask about your child's exposure to stressful life events

ADVERSE CHILDHOOD EXPERIENCES QUESTIONS

Many children experience stressful life events that can affect their health and wellbeing. The results from these questions will assist your child's doctor in assessing their health and determining appropriate guidance. Please read the statements below. Count the number of statements in each part that apply to your child and write the total number in the boxes provided.

Please **DO NOT** mark or indicate which specific statements apply to your child.

Information and resources about ACEs can be found at: *emergingminds.com.au→ resources→ toolkits→ adverse childhood experiences*

PART 1

Of these statements, **how many** apply to your child? Write the total number in the box. →

At any point since your child was born....

- Your child's parents or guardians are/were separated or divorced
- Your child lives/ lived with a household member who has served time in jail or prison
- Your child lives/ lived with a household member who is/was depressed, mentally ill or attempted suicide
- Your child sees or hears/ or has seen or heard, household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child goes/went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lives/lived with someone who has/had a problem with drinking or using drugs
- Your child often feels/felt unsupported, unloved and/or unprotected

PART 2

Of these statements, **how many** apply to your child? Write the total number in the box. →

At any point since your child was born....

- Your child is/ was in foster care
- Your child has experienced harassment or bullying at school or prior to starting Kindergarten
- Your child has lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child has/ had a serious medical procedure or life threatening illness
- Your child often sees or hears violence in the neighbourhood or in her/his school neighbourhood
- Your child is/ was often treated badly because of race, sexual orientation, place of birth, disability or religion

Adapted from the Center for Youth Wellness: The ACE Questionnaire ("CYW ACE-Q")

Thank you.

If you wish to keep the information page about the Kindergarten Health Check at home, please carefully tear off the first page only along the perforation.

Return the completed form to your child's school in a sealed envelope.

The results of the Kindergarten Health Check will be posted to your nominated address and to your GP if you have given permission.

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