

## Parent questionnaire on school entry examination

The school doctor requires the information given in response to questions 1 - 12 for the school doctor's/medical assessment in accordance with § 11 of the school ordinance for state primary schools in Rhineland-Palatinate. The information serves as a basis for the joint consultation and ascertainment of the stage of development of the child. A response to these questions is requested in each and every case. Any uncertainty regarding the meaning of individual questions can be discussed in the consultation.



**Rheinland-Pfalz**  
MINISTERIUM FÜR SOZIALES,  
ARBEIT, GESUNDHEIT  
UND DEMOGRAFIE

### 1. Family details

Completed on:        
Day Month Year

	Child	Mother	Father
Surname	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>		
Sex	male... <input type="checkbox"/> female... <input type="checkbox"/>		
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	Country of birth of child	<input type="text"/>

### 2. What institutions has your child attended so far? (Multiple answers possible)

- Crèche .....  Kindergarten/nursery school ....  Special needs kindergarten ..   
Day-care centre .....  Inclusive nursery school .....  No institution .....

The child has been attending the present institution for \_\_\_\_ years and \_\_\_\_ month(s).

Age of child at start of first care service outside the family: \_\_\_\_ years and \_\_\_\_ month(s).

### 3. What infectious diseases has your child already had?

- Chicken pox (varicella) .....  Mumps .....  Salmonellae .....   
Scarlet fever .....  German measles (rubella) ...  Lyme disease (borreliosis) ..   
Fifth disease (erythema infectiosum)  Whooping cough (pertussis) .  Encephalitis/meningitis .....   
Measles (rubeola) .....  Hepatitis B .....  Rotaviruses .....   
Other .....  If other, which? \_\_\_\_\_ None ...

### 4. What acute illnesses have become apparent in the last 12 months?

- Bronchitis .....  Cystitis/urinary tract infection .  Pseudocroup attack .....   
Throat infection/tonsillitis ...  Pneumonia .....  Cerebral seizure .....   
Middle ear inflammation .....  Fever convulsions .....  Frequent infections .....   
Gastroenteritis .....   
Other .....  If other, which? \_\_\_\_\_ None ...

### 5. Has your child ever had the following impairments/disabilities/handicaps diagnosed by a doctor? If so, please bring along relevant documentation!

- Allergies .....  Adenoids (polypi) .....  Seizures (epilepsy) .....   
Neurodermatitis (atopic eczema)  Spinal column disorders .....  Tumour diseases/cancer ....   
Chronic bronchitis .....  Thyroid disease .....  Rheumatism .....   
Bronchial asthma .....  Heart failure/heart disease ...  Autism .....   
Hay fever .....  Juvenile diabetes .....  Congenital disorder .....   
Food allergy .....  Chronic urinary tract infections .  Physical disability .....   
Allergic skin rashes (eczema) ....  Attention deficit syndrome .....  Mental deficiency .....   
Other .....  If other, which? \_\_\_\_\_ None ...

**6. Has your child had any of the following symptoms or abnormalities in the last 12 months?**

- |                                |                          |                                       |                          |  |                          |                          |
|--------------------------------|--------------------------|---------------------------------------|--------------------------|--|--------------------------|--------------------------|
| Visual impairment .....        | <input type="checkbox"/> | Worm infections (helminthiasis) ..... | <input type="checkbox"/> | Food intolerance .....                     | <input type="checkbox"/> |                          |
| Hearing impairment .....       | <input type="checkbox"/> | Overweight.....                       | <input type="checkbox"/> | Motor agitation/hyperactivity .....        | <input type="checkbox"/> |                          |
| Speech abnormalities .....     | <input type="checkbox"/> | Underweight .....                     | <input type="checkbox"/> | Aggression.....                            | <input type="checkbox"/> |                          |
| Developmental delay .....      | <input type="checkbox"/> | Frequent headaches .....              | <input type="checkbox"/> | Problems falling/remaining asleep.....     | <input type="checkbox"/> |                          |
| Concentration disorder.....    | <input type="checkbox"/> | Frequent abdominal pain....           | <input type="checkbox"/> | Frequent snoring (without infection) ..    | <input type="checkbox"/> |                          |
| Bedwetting.....                | <input type="checkbox"/> | Frequent leg aches .....              | <input type="checkbox"/> | Mouth breathing/impaired nasal breathing . | <input type="checkbox"/> |                          |
| Soiling (fecal incontinence).. | <input type="checkbox"/> | Anxiety .....                         | <input type="checkbox"/> | Excessive daytime sleepiness .....         | <input type="checkbox"/> |                          |
| Other .....                    | <input type="checkbox"/> | If other, which? _____                |                          |  | None....                 | <input type="checkbox"/> |

**7. What doctors or therapists has your child visited in the last 12 months?**

- |                            |                          |                        |                          |   |                          |                          |
|----------------------------|--------------------------|------------------------|--------------------------|---|--------------------------|--------------------------|
| Paediatrician .....        | <input type="checkbox"/> | Ophthalmologist .....  | <input type="checkbox"/> | Non-medical practitioner .....          | <input type="checkbox"/> |                          |
| General practitioner ..... | <input type="checkbox"/> | ENT specialist .....   | <input type="checkbox"/> | Child and adolescent psychiatrist ..... | <input type="checkbox"/> |                          |
| Dentist .....              | <input type="checkbox"/> | Dermatologist .....    | <input type="checkbox"/> | Psychologist.....                       | <input type="checkbox"/> |                          |
| Orthodontist .....         | <input type="checkbox"/> | Urologist .....        | <input type="checkbox"/> | Surgeon/orthopaedist .....              | <input type="checkbox"/> |                          |
| Other .....                | <input type="checkbox"/> | If other, which? _____ |                          |   | None....                 | <input type="checkbox"/> |

**8. Has your child ever undergone the following examinations or treatments?**

- |  |                          |   |
|--|--------------------------|---|
|  |                          | Details (e.g. Outpatient operation: Adenoids) |
| Developmental diagnosis .....                | <input type="checkbox"/> | _____   |
| Stay at health/rehabilitation facility ..... | <input type="checkbox"/> | _____   |
| Allergy test .....                           | <input type="checkbox"/> | _____   |
| Outpatient operation.....                    | <input type="checkbox"/> | _____   |
| Inpatient hospital treatment .....           | <input type="checkbox"/> | _____   |
| No examinations/treatments .....             | <input type="checkbox"/> |   |

**9. What treatments or support has your child received so far?**

- |                                  |                          |                                  |                          |                                  |                          |                          |
|----------------------------------|--------------------------|----------------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| Speech therapy/logopaedics ..... | <input type="checkbox"/> | Early intervention.....          | <input type="checkbox"/> | Curative educational treatment.. | <input type="checkbox"/> |                          |
| Ergotherapy .....                | <input type="checkbox"/> | Speech therapy in nursery school | <input type="checkbox"/> | Psychotherapy.....               | <input type="checkbox"/> |                          |
| Physiotherapy.....               | <input type="checkbox"/> | Integration support .....        | <input type="checkbox"/> | Family assistance .....          | <input type="checkbox"/> |                          |
| Orthodontic treatment.....       | <input type="checkbox"/> | Educational guidance.....        | <input type="checkbox"/> | Psychological advice.....        | <input type="checkbox"/> |                          |
| Other .....                      | <input type="checkbox"/> | If other, which? _____           |                          |                                  | None....                 | <input type="checkbox"/> |

**10. Has your child ever had an accident or been exposed to poisoning that has required medical treatment?**

- |   |                          |                          |                          |                 |                          |
|---|--------------------------|--------------------------|--------------------------|-----------------|--------------------------|
| Accident at home .....                            | <input type="checkbox"/> | Road accident .....      | <input type="checkbox"/> | Poisoning ..... | <input type="checkbox"/> |
| Accident at nursery school/school/association ... | <input type="checkbox"/> | Accident elsewhere ..... | <input type="checkbox"/> | None .....      | <input type="checkbox"/> |

**11. Has your child taken any medication in the last year?**

- No ...  Yes...
- | If so, for               | Regularly                | As required              | Name of medication |
|--------------------------|--------------------------|--------------------------|--------------------|
| Allergies .....          | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Asthma .....             | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Epilepsy (seizures)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Hyperactivity .....      | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Other ailments .....     | <input type="checkbox"/> | <input type="checkbox"/> | _____              |

**12. Is there any other information you would like to give us about your child?**

\_\_\_\_\_

**Answering questions 12 - 22 is optional!**

These questions primarily serve the state-wide health reporting system. Both the school entry examination and subsequent examinations or assessments are independent thereof.

If in doubt, you may leave individual questions unanswered. Please be assured that you or your child will not suffer any disadvantages as a result.

**13. For how long was your child breastfed?**

- a. Not breastfed.....      Less than 1 month .....      1 - 3 months .....  
 4 - 6 months .....      Over 6 months.....      Not known .....
- b. My child was exclusively breastfed up to its   month of life      Not known .....

**14. Who does your child generally live with? (Please mark only one box with a cross.)**

- With its birth parents .....      In a home .....  
 With its mother and partner .....      With foster parents/adoptive parents .....  
 With its mother as single parent .....      With other family members.....  
 With its father and partner.....      With other people .....  
 With its father as single parent.....

**15. How many children in total live in your household? (including the child to be enrolled at school)**

1 child  2 children  3 children  4 children  More than 4 children  How many? \_\_\_\_\_

**16. What languages are spoken at home? (Multiple answers possible)**

German ...      Other languages ...       Which? \_\_\_\_\_

**17. What country were you born in? (Please indicate for both parents.)**

**Mother**.... In Germany .....      In another country.....      In which? \_\_\_\_\_  
**Father** .... In Germany .....      In another country.....      In which? \_\_\_\_\_

**18. What nationality are you? (Please indicate for the child and both parents.)**

**Child** ..... German ...      Other/additional nationality.....      Which? \_\_\_\_\_  
**Mother**.... German ...      Other/additional nationality.....      Which? \_\_\_\_\_  
**Father** .... German ...      Other/additional nationality.....      Which? \_\_\_\_\_

**19. Does anybody in your household smoke?**

Never...      Occasionally...      Frequently...

**20. What is your highest qualification level? (Please indicate for both parents!)**

	Mother/ female custodian	Father/ male custodian
Elementary school/primary school leaving certificate.....	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate school leaving certificate .....	<input type="checkbox"/>	<input type="checkbox"/>
Higher secondary vocational school leaving certificate.....	<input type="checkbox"/>	<input type="checkbox"/>
General high school leaving certificate (Abitur) for university entrance .....	<input type="checkbox"/>	<input type="checkbox"/>
Other school-leaving certificate .....	<input type="checkbox"/>	<input type="checkbox"/>
(Still) receiving school education (pupil).....	<input type="checkbox"/>	<input type="checkbox"/>
Left school without school leaving certificate .....	<input type="checkbox"/>	<input type="checkbox"/>

**21. Have you completed any vocational training? If so, which?**

(Please state only the most advanced level of qualification. Please indicate for both parents!)

	Mother/ female custodian	Father/ male custodian
Apprenticeship/traineeship (trade/professional).....	<input type="checkbox"/>	<input type="checkbox"/>
Vocational/commercial college (trade/professional) .....	<input type="checkbox"/>	<input type="checkbox"/>
Technical college (e.g. master/technician school, professional academy) .....	<input type="checkbox"/>	<input type="checkbox"/>
Polytechnic, school of engineering.....	<input type="checkbox"/>	<input type="checkbox"/>
University, institution of higher education.....	<input type="checkbox"/>	<input type="checkbox"/>
Other training qualification .....	<input type="checkbox"/>	<input type="checkbox"/>
Still receiving professional education .....	<input type="checkbox"/>	<input type="checkbox"/>
No qualifications .....	<input type="checkbox"/>	<input type="checkbox"/>

**22. Who has completed the questionnaire?**

- |  |   |   |   |
|--|---|---|---|
| Mother/female custodian ... <input type="checkbox"/> | Grandmother ... <input type="checkbox"/>  | Foster mother .... <input type="checkbox"/> | Sibling of the child.... <input type="checkbox"/> |
| Father/male custodian ..... <input type="checkbox"/> | Grandfather .... <input type="checkbox"/> | Foster father .... <input type="checkbox"/> | Other person..... <input type="checkbox"/>        |