



**Queensland
Government**

**Child Development
School Questionnaire**

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: M F I

A word to Teachers

Thank you for taking the time to fill in this questionnaire. Your answers to these questions will support the management of this child. Your input is valuable in enabling proper screening, referral, assessment and management of the child. Please feel free to complete it in collaboration with others in the school who are involved with the child.

If you are suggesting to the parent/carer a review of the child by a GP, please encourage them to provide this information to the GP at the time of appointment to inform his/her assessment of the child.

If this information was directly requested by Sunshine Coast Hospital and Health Service, please return it to the appropriate address at the bottom of the last page.

The child's details

Child's name: Sex: Male Female

Date of birth: ____ / ____ / ____ Year level at school:

When does the child attend your program?

Your details

Your name: Position:

Date questionnaire completed: ____ / ____ / ____ Your signature:

Email address: Best contact day/time:

School details

School name:

School address:

Suburb: Postcode:

Phone number: Fax number:

Teacher ratings

OVERALL, if the child is experiencing difficulties at your school, please indicate to what degree:

Educational: None Mild Moderate Severe

Behavioural: None Mild Moderate Severe

Social skills: None Mild Moderate Severe

Emotions: None Mild Moderate Severe

What are your main concerns about this child? Please describe:

.....

.....

.....

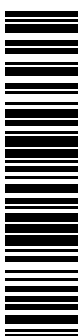
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2018/08 V4.1



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Which areas of the child's development would you like information or assistance? (How can we help with this child?)

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.....
.....
.....

What are the child's positive qualities?

.....
.....
.....
.....

Support services

Has this child ever been involved with any of the following professionals or programs at your school?
(please tick)

With parents permission please attach any relevant reports.

	Never	In the past	Currently	Not known
EAP / Appraisalment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guidance Officer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech and language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselling program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine motor/gross motor program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioural support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you ticked 'In the past' or 'Currently' for any support services involvement, please describe below - who, when, what for and how long?

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.....
.....

Please describe any specific strategies you are using to assist the child:

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.....
.....
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Do you have **any concerns** about the child in the following areas:

Area of development	No concerns	Somewhat concerned	Very concerned	Unsure
Language comprehension Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spoken language Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Literary skills including reading, spelling and written expression Comments: Estimated year level: reading spelling Formal test results (NAPLAN, Neale, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numeracy Comments: Estimated year level maths Formal test results (NAPLAN, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine motor skills/handwriting Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross motor skills Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention / distractability / impulse control Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Organisational skills Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour in playground Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social interaction with peers Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional well-being/self-esteem Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any Additional Comments:

.....

.....

.....

Thank you for completing this questionnaire.

If you are suggesting to the parent/carer a review of the child by a GP, please encourage them to provide this information to the GP to inform his/her assessment of the child.

If this information has been requested by the Sunshine Coast Hospital and Health Service, please return it to the appropriate service below:

Child Development Service Caloundra Health Service West Terrace Caloundra QLD 4551 Ph: 5436 8910 Fax: 5436 8584 Email: Child-Development-Service@health.qld.gov.au	Paediatric Outpatient Department Gympie Hospital Locked Bag 15 Gympie QLD 4570 Phone: 5489 8536 Fax: 5489 8717 Email: GY-admin-SOPS@health.qld.gov.au	Children's and Adolescent's Clinic Sunshine Coast University Hospital 6 Doherty Street Birtinya QLD 4575 Phone: 5202 3415 Fax: 5202 2688 Email: SC-Paediatric-Outpatients@health.qld.gov.au
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