

Medical history sheet

Instructions for filling out this form: Please fill in or tick as appropriate ☒

We ask you to provide the following information so that we can carry out the school entrance examination completely and give you qualified advice. Data processing is based, among other things, on Art. 12 Para. 1 of the Health Services Act, § 6 Para. 1 No. 1 of the School Healthcare Ordinance. Further information on data processing can be found in the data protection information that you received with the invitation to attend the school entrance examination.

The child's family name	First name of the child	Date of birth
Number of siblings	Child's nationality	Child's country of birth
Name and address of the legal guardian		
Name, First Name..... Name, First Name		
Tel. Tel.		
Address:		
Kindergarten		
Duration of crèche/daycare/kindergarten attendance (in years): _____		
Does your child currently attend a kindergarten? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of kindergarten:		
<input type="checkbox"/> Regular kindergarten (incl. forest kindergarten, Montessori, etc.) <input type="checkbox"/> Preparatory school facility (SVE)		
<input type="checkbox"/> Therapeutic daycare centre (HPT) <input type="checkbox"/> Integration place / integration kindergarten		
<input type="checkbox"/> Other (Which?): _____		
Pregnancy and delivery (Information in the yellow booklet)		
Weight at birth: _ _ _ _ grams Completed weeks of pregnancy: _ _ weeks <input type="checkbox"/> Multiple birth		
Development		
Speech abnormalities in development <input type="checkbox"/> Yes <input type="checkbox"/> No		
Child grows up multilingual <input type="checkbox"/> Yes <input type="checkbox"/> No		
Contact with the German language <input type="checkbox"/> since birth <input type="checkbox"/> not since birth		
If contact with the German language has not been since birth, then at what age? _ years _ _ months		
Parents' mother tongue (please specify for both parents)?		
<input type="checkbox"/> German <input type="checkbox"/> Other (which?): _____		
<input type="checkbox"/> German <input type="checkbox"/> Other (which?): _____		
Which languages are spoken in your home?		
<input type="checkbox"/> German <input type="checkbox"/> Other language(s) (which?): _____		
Is your child <input type="checkbox"/> right-handed <input type="checkbox"/> left-handed <input type="checkbox"/> still undecided		
Would you say that, overall, your child has difficulties in one or more of the following areas: mood (gloomy, anxious, unstable, short-tempered), concentration (cannot sit still for long, does not listen persistently when being read to), behaviour, interaction with others?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Supporting measures or treatments			
Participation in the preliminary course in German	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> is planned
Speech therapy	<input type="checkbox"/> No	<input type="checkbox"/> completed	<input type="checkbox"/> is currently in progress <input type="checkbox"/> is planned
Information on pre-existing diseases or health restrictions			
Has your child ever been examined by an ophthalmologist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, the following was determined or initiated:</i>			
<input type="checkbox"/> No abnormal findings	<input type="checkbox"/> Glasses have been prescribed		
<input type="checkbox"/> Short-sightedness (myopia)	<input type="checkbox"/> Long-sightedness (hypermetropia)	<input type="checkbox"/> Squinting	
Have you taken your child to the dentist in the past 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital severe hearing impairment		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please answer the following questions:</i>			
Congenital hearing impairment	<input type="checkbox"/> left	<input type="checkbox"/> right	<input type="checkbox"/> bilateral
Hearing aid provided	<input type="checkbox"/> left	<input type="checkbox"/> right	<input type="checkbox"/> bilateral
Cochlear implant provided	<input type="checkbox"/> left	<input type="checkbox"/> right	<input type="checkbox"/> bilateral
Metabolic / hormone disorders (only medically diagnosed findings)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, which ones:</i> <input type="checkbox"/> MCAD deficiency <input type="checkbox"/> Hypothyroidism (congenital)			
<input type="checkbox"/> PKU	<input type="checkbox"/> AGS	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Diabetes mellitus (type 1)
<input type="checkbox"/> Other:			
<i>Age at diagnosis:</i> __ __ __ (years / months)			
Other chronic diseases:	<input type="checkbox"/> Yes (<i>Which ones?</i>):	<input type="checkbox"/> No	
Severe disability:	<input type="checkbox"/> Yes (<i>Which one?</i>):	<input type="checkbox"/> No	
Medications to be taken regularly:	<input type="checkbox"/> Yes (<i>Which ones?</i>):.....	<input type="checkbox"/> No	
Are you aware of your child's illnesses that require certain procedures in emergency situations (e.g. allergies, epilepsy, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>If yes, which illnesses?</i>			
Do the following exist in your family (parents, siblings)			
▶ A reading and spelling weakness (dyslexia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
▶ A weakness in arithmetic (dyscalculia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Completed on: