

1. Notes to the Person

Child's Last Name: _____ First Name: _____

Sex: male female

Date of birth: ____ . ____ . ____

Citizenship(s): _____

Born in Germany: yes no

Since when has your child lived in Germany (month/year)?

Siblings younger than 18 years:

First Name	Year of birth	First Name	Year of birth
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Please enter **the child's** parents (**only persons entitled**):

Mother's Last Name: _____ First Name: _____

Father's Last Name: _____ First Name: _____

Address: _____ Telephone: _____

Country of birth of mother: _____ of father: _____

Nationality

of mother: German yes no other: _____

of father: German yes no other: _____

Languages spoken in your family:

1. _____ 2. _____ 3. _____

Name of your pediatrician/family doctor: _____

2. Child's Health and Medical History:

- | | | | | |
|-----|---|---------------------------|--------------------------|----------------------------------|
| 2.1 | Chicken pox | yes <input type="radio"/> | no <input type="radio"/> | don't know <input type="radio"/> |
| 2.2 | Asthmatic bronchitis/Asthma | yes <input type="radio"/> | no <input type="radio"/> | don't know <input type="radio"/> |
| 2.3 | Congenital heart defect/heart disease | yes <input type="radio"/> | no <input type="radio"/> | don't know <input type="radio"/> |
| 2.4 | Convulsions (epileptic seizures) | yes <input type="radio"/> | no <input type="radio"/> | don't know <input type="radio"/> |
| 2.5 | Does your child require medication regularly? | yes <input type="radio"/> | no <input type="radio"/> | don't know <input type="radio"/> |

if yes, please list: _____

- | | | | | |
|-----|-------------------------------------|---------------------------|--------------------------|----------------------------------|
| 2.6 | other important illnesses/accidents | yes <input type="radio"/> | no <input type="radio"/> | don't know <input type="radio"/> |
|-----|-------------------------------------|---------------------------|--------------------------|----------------------------------|

if yes, which illnesses/accidents: _____

- | | | | | |
|-----|------------------|--------------------------------|----------------------------|----------------------------------|
| 2.7 | Hospitalizations | how often <input type="text"/> | none <input type="radio"/> | don't know <input type="radio"/> |
|-----|------------------|--------------------------------|----------------------------|----------------------------------|

3. Development of Your Child

- | | | | | |
|------|--|---------------------------|--------------------------|--|
| 3.1. | Has your child ever | | | |
| | undergone physical therapy? | yes <input type="radio"/> | no <input type="radio"/> | |
| | undergone occupational therapy? | yes <input type="radio"/> | no <input type="radio"/> | |
| | been treated by a speech therapist? | yes <input type="radio"/> | no <input type="radio"/> | |
| | been treated by psychologist/psychiatrist/family counseling? | yes <input type="radio"/> | no <input type="radio"/> | |
| 3.2. | Are you concerned about your child because of his or her | | | |
| | behaviour? | yes <input type="radio"/> | no <input type="radio"/> | |
| | speech development? | yes <input type="radio"/> | no <input type="radio"/> | |
| | concentration? | yes <input type="radio"/> | no <input type="radio"/> | |
| | vision or hearing? | yes <input type="radio"/> | no <input type="radio"/> | |
| 3.3 | Does your child wet its bed? | yes <input type="radio"/> | no <input type="radio"/> | |

4. Child care

- | | | | | |
|-----|---|--------------|---|-----------------------------|
| 4.1 | Since when has your child been cared for at a nursery school/Kinder-
garten/day care center? | month / year | <input type="text"/> <input type="text"/> | never <input type="radio"/> |
|-----|---|--------------|---|-----------------------------|

if yes, most recent: _____

- | | | | |
|-----|--|---------------------------|--------------------------|
| 4.2 | Is your child at present or has it been cared for by day-care or other child care? | yes <input type="radio"/> | no <input type="radio"/> |
|-----|--|---------------------------|--------------------------|

5. Your Child's Living Environment

- 5.1 The child lives predominantly with his/her
 Parents single mother single father
 Foster family relatives in a orphanage
- 5.2 Education (highest level completed, please fill in for **both** parents!)

	Mother	Father
No school leaving certificate	<input type="radio"/>	<input type="radio"/>
Fewer than 10 years	<input type="radio"/>	<input type="radio"/>
Lower secondary (through grade 10)	<input type="radio"/>	<input type="radio"/>
Upper secondary (grades 11-12 or 13)	<input type="radio"/>	<input type="radio"/>
- 5.3 Career Training (highest level completed, please fill in for **both** parents!)

	Mother	Father
No career training	<input type="radio"/>	<input type="radio"/>
Currently in training	<input type="radio"/>	<input type="radio"/>
Vocational Training completed	<input type="radio"/>	<input type="radio"/>
University Degree completed	<input type="radio"/>	<input type="radio"/>
- 5.4 Employment (please fill in for **both** parents!)

	Mother	Father
<i>Unemployed, because</i>		
Cannot find job	<input type="radio"/>	<input type="radio"/>
All other reasons	<input type="radio"/>	<input type="radio"/>
Part time	<input type="radio"/>	<input type="radio"/>
Full time	<input type="radio"/>	<input type="radio"/>
- 5.5 What is the number of people living in your household (including the child who is to enter school)?
 Adults: children under 18:
- 5.6 How many people in this household smoke? none
- 5.7 How many hours per day is your child occupied with electronic devices? (Electronic devices are e.g. TV, DVD, computer tablet, mobile phone playstation)
 Duration of occupation per day
 not at all My child has
 up to 1 hour his own TV
 up to 2 hours his own other electronic device
 up to 3 hours no electronic device of his own
 more than 3 hours

Declaration of Consent

I have been informed that completion of section 5 ("Living environment") of this questionnaire is voluntary. The collection and processing of all information contained herein is subject to the Public-Health Bureau Data-Protection regulation of June 1994.

This information is strictly confidential and will remain with the physician of the public pediatric health care service.

I agree that also information in section 5 ("Living environment") may be used **anonymously** (i.e. without names and addresses) for the monitoring, assessment, reporting and planning of public health.

Date

Signature
 Parent or legal guardian