

SECTION B: CULTURAL BACKGROUND

Knowing the child/adolescent's cultural background can help us provide healthcare that meets their individual needs.

Are they of Aboriginal and/or Torres Strait Islander origin?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Prefer not to say

Other cultural background (e.g. Mediterranean, Asian, African)		Country of Birth
Is English their first language? <input type="checkbox"/> Yes <input type="checkbox"/> No	Language(s) spoken at home:	
Do they require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION C: ALLERGIES AND MEDICINES

List any allergies to medicines or intolerances they have:	Describe their reaction:
<input type="checkbox"/> The child/adolescent has no known allergies to medicines.	
List any regular medicines they take, along with doses (if known). Include herbal or vitamin products.	
<input type="checkbox"/> The child/adolescent does not take any regular medicines.	

SECTION D: MEDICAL HISTORY

Please tick any relevant past medical history relevant to the child/adolescent:

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Cancer | <input type="checkbox"/> Learning Difficulties |
| <input type="checkbox"/> Premature | <input type="checkbox"/> Migraines | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Health Issue |

SECTION E: DEVELOPMENTAL HISTORY

Are all childhood vaccinations up to date? ☐ Yes ☐ No

Are there any smokers in the household? ☐ Yes ☐ No

Do you have any concerns about the child/adolescent's development? ☐ Yes ☐ No

SECTION F: CONSENT

Bridging Healthcare uses a reminder system to help you maintain your child/adolescent's health. The clinic sends reminders by email, post or SMS for reminder procedures like vaccinations and other health reviews they need. By signing below, you consent to being contacted for reminders relating to the planning and managing of their health. By signing below, you consent to the child's de-identified health information to be shared for the purposes of service improvement and research activities that provide insight into and improve community health and health services management.

Parent/Guardian Name (Printed) _____ Signature _____ Date _____