



## Nursery Extra information form

Childs Name.....

Did you child attend their 2 year check?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was your child born premature?	Yes <input type="checkbox"/> No <input type="checkbox"/>
How many weeks premature?	
Has your child ever been seen by any of the following –	
Occupational therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Physiotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child development clinic	Yes <input type="checkbox"/> No <input type="checkbox"/>
Speech and language	Yes <input type="checkbox"/> No <input type="checkbox"/>
Incontinence team	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ear, Nose and Throat team	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have they had their hearing checked?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have they had repeated ear infections such as glue ear?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have they had grommets fitted?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your child toilet trained?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Can they follow an instruction? (e.g. get your coat)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Can they speak in sentences? (e.g. I want drink)	Yes <input type="checkbox"/> No <input type="checkbox"/>



***Is there anything else you would like us to know?***