Health and Developmental Information

This form should be completed by a credentialed school nurse.

STUDENT: ______________________________________ Birthday: _____________ Sex: ____ Grade: ______ School Year: ___________
School: ____ Teacher: ____
Person providing history: ________________________________ Relationship to student: ________________ Language: ____________
Preferred phone: ______________________________________ Alternate phone: ____
Interview done by ❐Phone ❐In Person Interpreter (*if applicable*): ______________________________ Date of Interview: __________

RN Initials: ____ (1) Interviewee was informed that this information will be used to help determine child's educational needs.
2) This information will become part of the child's educational record and will be safeguarded against unauthorized use.
3) You can choose not to answer any questions without denial of eligible educational benefits.

PREGNANCY/BIRTH HISTORY

Birth weight: __________ Full term: ❐ Yes ❐ No If no, age in weeks at birth: ___________ ❐ Vaginal Delivery ❐ C-Section
If C-Section, please explain: ____
Month of pregnancy when prenatal care began: __________________________
Were there any problems during pregnancy? ❐ Yes ❐ No ____
Medications/alcohol/drugs/tobacco taken during pregnancy? ❐ Yes ❐ No ____
Any problems for mother or baby during/after delivery? ❐ Yes ❐ No ____
Did baby have to stay in hospital/receive special care after birth? ❐ Yes ❐ No ____
Any feeding difficulties in infancy? ❐ Yes ❐ No ____
Did baby pass newborn hearing screening? ❐ Yes ❐ No ____

DEVELOPMENTAL HISTORY

At what age did the child do the following: Sit Alone _____ Crawled _____ Stand Alone _____ Walk Alone ____ Speak first words _____
Speak Phrases _____ Toilet Trained _____ Are you, or has anyone, ever been concerned about the student's development? ❐Yes ❐No
If yes, explain: ____
Has the student ever received any physical, occupational, speech or language therapy? ❐ Yes ❐ No
If yes, explain: ____

HEALTH HISTORY

Has the student had a problem in the following areas? If YES, please provide details below:

Head Injury	❐Yes ❐No	Autism	❐Yes ❐No	Diabetes	❐Yes ❐No
Frequent/Severe Headaches	❐Yes ❐No	Emotional Disturbance	❐Yes ❐No	Skin Problems	❐Yes ❐No
Ear/Hearing Problems	❐Yes ❐No	Psychiatric Care	❐Yes ❐No	Surgery (reason/age)	❐Yes ❐No
Eye/Vision Problems	❐Yes ❐No	Back/Spine/Extremity Problems	❐Yes ❐No	Serious Accidents/Fractures	❐Yes ❐No
Convulsions/Seizures	❐Yes ❐No	Nerve or Muscle Disease	❐Yes ❐No	Genetic Disorder	❐Yes ❐No
Oral/Dental Problems	❐Yes ❐No	Heart Problems	❐Yes ❐No	Illnesses/Hospitalizations	❐Yes ❐No
Asthma/Breathing Problems	❐Yes ❐No	Eating/Stomach Problems	❐Yes ❐No	Other Health Concerns	❐Yes ❐No
ADD/ADHD	❐Yes ❐No	Urinary/Digestive/Bowel Problems	❐Yes ❐No		

If any of the above are marked "yes", please explain, and give age of student at problem onset/diagnosis (attach add'l. page if necessary):
____
____
____
____

List any other diagnosis, syndrome, or disability the student has or has had in the past. (List condition, treatment, who diagnosed, when etc.):
____
____
____

FAMILY HISTORY

Anyone in the family who has/had learning problems? Yes ❐ No ❐ If yes, please describe: ___________________________________
Anyone in the immediate family with a serious medical problem (heart problems, diabetes, cancer, etc.)? Yes ❐ No ❐
If yes, please describe: ____

STUDENT: ____ **Birthday**: _____________ **Sex**: ____ **Grade**: _____ **School Year**: ___________
School: ____ **Teacher**: ____

BEHAVIORAL HISTORY

Does the student currently have any emotional or behavior problems? ❒ Yes ❒ No If yes, please describe (include if student is currently receiving therapy/counseling) and any concerns you may have: ____

____
____
____

CURRENT MEDICAL HISTORY

How would you describe student's current health? ____
Any current or chronic health problems/limitations? ❒ Yes ❒ No ____
Any allergies to food, medication, environmental, etc.? ❒ Yes ❒ No If yes, Please list: ____
Are allergies life threating? ❒ Yes ❒ No Has student ever experienced anaphylaxis? ❒ Yes ❒ No _____________________________
Does student have any issues with nutrition? Dietary restrictions? ❒ Yes ❒ No ____
Sleep Habits - Normal Bedtime: __________ Number of hours of sleep: _______ Student wakes up rested? ❒ Yes ❒ No
Does Student: ❒ snore ❒ Wet pants/bed Has other sleep issues? ❒ Yes ❒ No Explain: _____________________________________
Attendance issues? ❒ Yes ❒ No Explain: ____
Is student taking any medications (prescribed, over the counter, herbal)? ❒ Yes ❒ No If yes, please list name, dose, and frequency:

____
____
____

HEALTH PROVIDERS

Primary Care Physician: ____ Date of last visit: _________________________________
Dental Provider: ____ Date of last visit: _______________________________
Specialist: ____ Date of last visit: _________________________________
Specialist: ____ Date of last visit: _________________________________
Specialist: ____ Date of last visit: _________________________________
Eye care provider (*if applicable*): ____ Date of last visit: _______________________________

Any other factors that you feel the school should be aware of concerning the student (such as frequent family moves, divorce, etc.)?
❒ Yes ❒ No If yes, explain: ____
____

Is there anything else you would like to discuss with the school nurse? ❒ Yes ❒ No If yes, explain: ____________________________
____
____

-- SCHOOL NURSE REVIEW --

DATE SCREENING RESULTS

_____________ Height ____________ Weight _____________ BMI ____________ Comments: ____________________________________
_____________ Vision Near R ___________ L ___________ Far R ___________ L ___________ Wears glasses/contacts: ❒ Yes ❒ No
If unable to test, is functional vision adequate? Explain: ____
_____________ Hearing R __________ L ___________ If unable to test, is functional hearing adequate? Explain: __________________
_____________ Dental ❒ Normal ❒ Abnormal Comments: ____
_____________ Other screenings/results: ____
Screening notes: ____
____
❒ Immunizations attached Notes: ____

School Nurse Signature: ____ Date: ________________________

STUDENT: ____ **Birthday**: ______________ **Sex**: ____ **Grade**: _____ **School Year**: ___________
School: ____ **Teacher**: ____

Addendum/Notes: