INITIAL HEALTH AND DEVELOPMENTAL HISTORY

Date: _____ School: _____

Student: _____ Birthdate: _____ Age: _____ Grade: _____

Address: _____ Home Phone: _____

City, State, Zip Code: _____

Mother's/Guardian's Name: _____ Cell Phone: _____

Father's/Guardian's Name: _____ Cell Phone: _____

Parent/Guardian signature: _____ Relationship to student: _____

Family Medical History:

Please list any family medical or emotional concerns: _____

_____

_____

Pregnancy and Birth History:

Mother's age at birth of child: _____ When did prenatal care begin? _____

Mother's physical and emotional health during pregnancy: _____

Total number of pregnancies: _____ This child was pregnancy number: _____

Did you experience any problems with this pregnancy?

_____

_____

Tobacco	Yes / No	Frequency/Amount: _____
Drug Use	Yes / No	Frequency/Amount: _____
Alcohol	Yes / No	Frequency/Amount: _____
Vitamins	Yes / No	Frequency/Amount: _____
Medications	Yes / No	Frequency/Amount: _____

Length of labor: _____ Birth: (Circle all that apply) Full Term / Premature: Number of weeks early_____

Vaginal / Caesarean / Breech / Forceps / Induction /Scheduled / Emergency

Please explain in detail:_____

Apgar score if known: _____ Birth weight: _____ Birth Length: _____

Baby's condition at birth? Jaundice, Cyanosis (poor color), Difficulty breathing, Difficulty eating. Please explain: _____

_____

Home from the hospital in _____ days.

Special medical attention needed the first year of life: _____

_____

Developmental History:

Were there any feeding concerns? Yes / No _____

Were there any toileting concerns (bladder or bowel)? Yes /No _____

Were there any concerns about fine or gross motor movement or coordination? Yes / No _____

Age of sitting: _____ Age of walking: _____ Age of talking: _____

Was there a history of speech, hearing, or visual concerns? Yes / No _____

Did the child receive speech / vision / physical / or occupational therapy? (Circle)

- Diagnosis: _____
- Therapy Facility: _____ Start Date: _____ End Date: _____
- Outcome:_____

Medical History:

Respiratory (Asthma, Bronchitis, etc.): Yes /No	Heart: Yes / No	Immune: Yes / No
Severe Allergies: Yes / No	Blood: Yes / No	Hearing: Yes / No
Diabetes: Yes / No	Orthopedic: Yes / No	Vision: Yes / No
Head Injury: Yes / No	Skin: Yes / No	Growth/Nutritional: Yes / No
Seizures/Neurological: Yes / No	Bladder/Kidney: Yes / No	Developmental: Yes / No
Headaches / Dizziness / Fainting: Yes / No	Stomach/Intestines: Yes / No	Other Health: Yes / No

Emotional/Behavior/Social (sad, mad, worried, overactive, sensory, repetitive behaviors, etc.) Yes / No

If yes to any of the above, please explain in detail:

_____

_____

Current Diagnoses:

1. Diagnosis: _____

   Doctor/Healthcare Provider: _____Specialty: _____

Frequency/Duration of appointments: _____

Date of first appointment: _____Discharge Date: _____ Continues to see: _____

2. Diagnosis: _____

Doctor/Healthcare Provider: _____Specialty:_____

Frequency/Duration of appointments: _____

Date of first appointment: _____ Discharge Date: _____ Continues to see: _____

Current Medications:

1. Medication: _____ Dose: _____ Frequency:_____ Taken at: Home / School

Diagnosis: _____Start date: _____ Doctor: _____

2. Medication: _____ Dose: _____ Frequency:_____ Taken at: Home / School

Diagnosis: _____Start date: _____ Doctor: _____

3. Medication: _____ Dose: _____ Frequency:_____ Taken at: Home / School

Diagnosis: _____ Start date: _____ Doctor: _____

Medication History: Please list any significant previous medication history: _____

_____

_____

Hospitalizations:

1. Hospital: _____ Admission and Discharge Dates: _____

Diagnosis: _____ Doctor: _____

Additional Information:

_____

_____

2. Hospital: _____ Admission and Discharge Dates: _____

Diagnosis: _____ Doctor: _____

Additional Information:

_____

_____

Illnesses, Accidents, and/or Injuries: _____

_____

General Wellness:

Extracurricular activities: (friends, sports, reading, TV, video games, hiking, cooking, music, etc…)

_____

_____

Exercise:

_____

_____

Sleep Habits:

_____

_____

Eating Habits:

_____

_____

Dental Health: _____

_____

Other: _____

_____

Do you believe the medical history has any impact on you son/daughter's educational performance? Yes / No

Please return this completed document to the School Nurse.