Office of the School Nurse

Social/Family/Medical History
Grade 6-12

Dear Parent, The information you provide will help the Medically Related Services Department and school's Case Study Committee in identifying your child's needs.

I. FAMILY INFORMATION

CHILD'S ______________________ ______________ ______________
NAME: GRADE BIRTH DATE

SPONSOR'S
Name: ______________________ Duty Phone ______________ Home Phone ______________

SPOUSE
Name: ______________________ Duty Phone ______________ Cell Phone ______________

II. MEDICAL HISTORY::

If your child has had any of the following serious medical illnesses or problems, please indicate below.

Condition	Yes	No
Frequent ear infections		
Frequent ear fluid		
Hearing problems		
Allergies		
Fainting		
Severe reaction to injection		
Swallowing problems		
Drooling		
Dental problems		
Eye problems		
Asthma		
Headaches		
Breath holding spells		
Awkwardness		
Weakness		
Muscle problems		
Chronic cough		
Bronchitis		
Chronic diarrhea		
Slow weight gain		
Kidney problems		
Genital problems		
Joint problems		
Arthritis		
Thyroid disease		
Chronic skin problems		
Limp		

Condition	Yes	No
Dizziness		
Heart disease		
Loss of consciousness		
Frequent sore throats		
Prolonged fever		
Encephalitis		
Severe reaction to medication		
Seizures/convulsions		
Meningitis		
Head trauma		
Accidents		
Poisoning/ingestions		
Low blood count/anemia		
Excessive bleeding		
Paralysis		
Emotional problems		
Tremors		
Tingling in hands/feet		
Unusual walk		
Chicken pox		
Mumps		
Measles		
Scarlet fever		
Whooping cough		
Constipation		
Long term separation from mother/father		

III. PREGNANCY and BIRTH

A. List all pregnancies (including miscarriages, abortions, and live births)

Date	Length of Pregnancy	Birth Weight	Outcome	Complications (Prolonged Hospital Stay)
________	__________	___________	______________	_______________________
________	__________	___________	______________	_______________________
________	__________	___________	______________	_______________________

B. Prenatal History - (Questions refer to the pregnancy with the child who is being evaluated.)

1. Did you take any medication during the pregnancy? [ ] Yes [ ] No
   Explain: ____
2. Did you smoke cigarettes during the pregnancy? [ ] Yes [ ] No
3. Did you drink alcohol during the pregnancy? [ ] Yes [ ] No
4. Did you use any illegal drugs during pregnancy? [ ] Yes [ ] No
5. Was this a planned pregnancy? [ ] Yes [ ] No
6. Did any of the following occur during the pregnancy

	Yes	No		Yes	No		Yes	No
Fever	[ ]	[ ]	Viral infection	[ ]	[ ]	German measles	[ ]	[ ]
Spotting	[ ]	[ ]	Kidney infection	[ ]	[ ]	Vaginal bleeding	[ ]	[ ]
Diabetes	[ ]	[ ]	Threatened miscarriage	[ ]	[ ]	Morning sickness	[ ]	[ ]
Toxemia	[ ]	[ ]	Sugar/protein in urine	[ ]	[ ]	Special diet	[ ]	[ ]
Surgery	[ ]	[ ]	RH factor problem	[ ]	[ ]	Accident/injury	[ ]	[ ]
Amniocentesis	[ ]	[ ]	Convulsions/seizures	[ ]	[ ]	Pre-term labor	[ ]	[ ]
Asthma	[ ]	[ ]	High blood pressure	[ ]	[ ]	X-rays	[ ]	[ ]

7. How long was labor? ____

8. How was the baby delivered? [ ] Vagina [ ] C-section [ ] Forceps/Vacuum assist

C. Infant's Condition at Birth

Birth weight: __________Length:___________Head circumference:___________APGAR scores:_________

	Yes	No		Yes	No
Breathed immediately	[ ]	[ ]	Had seizures or convulsions	[ ]	[ ]
Cried immediately	[ ]	[ ]	Had infection	[ ]	[ ]
Resuscitation required	[ ]	[ ]	Had skin rash	[ ]	[ ]
Was jaundiced (yellow)	[ ]	[ ]	Had bleeding problem	[ ]	[ ]
Was blue	[ ]	[ ]	Had low blood sugar	[ ]	[ ]

D. Procedures or treatments use with infant:

	Yes	No		Yes	No
Fluids by needle (IV)	[ ]	[ ]	Feeding by tube	[ ]	[ ]
Transfusion	[ ]	[ ]	Incubator	[ ]	[ ]
Oxygen therapy	[ ]	[ ]	Breathing machine	[ ]	[ ]
Special lights for jaundice	[ ]	[ ]	Chest tubes	[ ]	[ ]
Medication	[ ]	[ ]	Antibiotics for infection	[ ]	[ ]

IV. DEVELOPMENT PROFILE

A. At what age did your child:

______Roll over	______Smile responsively	______Use fingers to eat
______Reach for objects	______Babble	______Use utensil to eat
______Sit alone	______Wave bye-bye	______Undress self
______Crawl	______Say first word	______Dress self
______Walk alone	______Put words together	______Toilet train
______Walk upstairs	______Say 3 word sentence	______Button clothes
______Pedal tricycle	______Say own name	______Tie shoes
______Skip	______Use pronouns	______Know some letters

B. Did your child exhibit any of the following during the first two years?

	Yes	No	Comment
1. Sleeping difficulties	[ ]	[ ]	______
2. Rhythmic behaviors (rocking)	[ ]	[ ]	______
3. Hard to comfort or console	[ ]	[ ]	______
4. Floppiness (after 6 months)	[ ]	[ ]	______
5. Stiffness	[ ]	[ ]	______
6. Cried often and easily	[ ]	[ ]	______
7. Not affectionate	[ ]	[ ]	______
8. Poor eye contact	[ ]	[ ]	______
9. Head banging	[ ]	[ ]	______
10. Did not like being held	[ ]	[ ]	______

V. FAMILY HISTORY

Please indicate with a check mark on the chart below for anyone in the family who has had any of the problems listed.

	Other Children	Child's Father	Child's Mother	Father's Family	Mother's Family
1. Depression /Psychiatric	[ ]	[ ]	[ ]	[ ]	[ ]
2. Alcohol problems	[ ]	[ ]	[ ]	[ ]	[ ]
3. Drug problem	[ ]	[ ]	[ ]	[ ]	[ ]
4. In trouble with the law	[ ]	[ ]	[ ]	[ ]	[ ]
5. Seizures/convulsions	[ ]	[ ]	[ ]	[ ]	[ ]
6. Neurological disease	[ ]	[ ]	[ ]	[ ]	[ ]
7. Cerebral Palsy	[ ]	[ ]	[ ]	[ ]	[ ]
8. Muscle tics/twitches	[ ]	[ ]	[ ]	[ ]	[ ]
9. Thyroid disorders	[ ]	[ ]	[ ]	[ ]	[ ]
10. Genetic diseases	[ ]	[ ]	[ ]	[ ]	[ ]
11. Difficulty with right and leftD	[ ]	[ ]	[ ]	[ ]	[ ]

VI. PRESENT CHILD BEHAVIORS

Do you have concerns about your child's behaviors in any of the following areas?

	Yes	No		Yes	No
Lacks motivation	[ ]	[ ]	Nervous habits	[ ]	[ ]
Seems confused	[ ]	[ ]	Frustrated easily	[ ]	[ ]
Mean or nasty	[ ]	[ ]	Cruel to animals	[ ]	[ ]
Is a "loner"	[ ]	[ ]	Problems sleeping	[ ]	[ ]
Lacks self-confidence	[ ]	[ ]	Usually tired	[ ]	[ ]
Unusual interest in fires	[ ]	[ ]	Trouble with the police	[ ]	[ ]
Not liked by others	[ ]	[ ]	Uses foul language	[ ]	[ ]
Intentionally injures self	[ ]	[ ]	Frequent physical complaints	[ ]	[ ]
Sucks thumb or objects	[ ]	[ ]	Is overactive/'tiyper"	[ ]	[ ]
Substance usage	[ ]	[ ]	Acts like child of opposite sexD	[ ]	[ ]
Lies	[ ]	[ ]	Eats things that aren't food (dirt, paper, etc.)	[ ]	[ ]
Fearless	[ ]	[ ]			

Do you have any concerns and/or information not listed above that would help us better assist your child?

Signature of Parent/Guardian Date

Signature of Evaluator Date