"Insert Name of School"
Office of the School Nurse

Social/Family/Medical History
MIDDLE SCHOOL

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

CHILDS'S _____ _____ _____
Name Grade Birthdate

First Language:_____ Number of Years in English Speaking Schools: _____
Language(s) Currently Used at Home: _____

FATHER'S _____ _____ _____
Name (last, first) Age Occupation
Living in home? [ ] Yes [ ] No Father's Native Language:_____
Relationship: Biological Father [ ] Step-Father [ ] Other [ ]

MOTHER'S _____ _____ _____
Name (last, first) Age Occupation
Living in home? [ ] Yes [ ] No Mother's Native Language:_____
Relationship: Biological Mother [ ] Step-Mother [ ] Other [ ]

OTHER CHILDREN IN THE HOME

Name (last, first)	Age	Name of School
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER PERSONS LIVING IN THE HOME

Name	Age	Name of School
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

II. IDENTIFICATION OF CONERNS

A. How do you think the school can best help your child?

_____

B. What are your child's strengths?

_____

C. Please list concerns you have about your child (be specific):

_____

D. Has your child had any serious medical illnesses or problems? [ ] Yes [ ] No

Please explain: _____

E. Is your child on medication? [ ] Yes [ ] No Name of Medication:_____

Please explain purpose:_____

F. Please list your child's past evaluations and/or treatments provided by schools, physicians, clinics, counselors, or psychologists:

Date	Where	What were the results?
_____	_____	_____
_____	_____	_____
_____	_____	_____

G. Has your child participated in any school programs? [ ] Yes [ ] No

Special programs? [ ] Yes [ ] No

Please explain: _____

III. FAMILY HISTORY

Please indicate 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. Hyperactive as a child					
2. Trouble learning to read					
3. Trouble with arithmetic					
4. Difficulty with coordination					
5. Difficulty with penmanship					
6. Left hand dominance					
7. Speech/language problems					
8. Kept back in school					
9. Mental retardation					
10 Behavior problems as child					
11. Vision problems					
12. Hearing problems					
13. Birth defects					
None of the above apply					

IV. PREGNANCY AND BIRTH

Please recall the following the best you can:	Yes	No	Comments
1. Was mother ill during pregnancy?	[ ]	[ ]	_____
2. Did mother take mediction?	[ ]	[ ]	_____
3. Was the baby premature?	[ ]	[ ]	_____
4. Did the baby have trouble breathing?	[ ]	[ ]	_____
5. Was an extended hospital stay required?	[ ]	[ ]	_____
6. Was the baby's birth weight low/high?	[ ]	[ ]	_____
7. Were any birth injuries noted?	[ ]	[ ]	_____
8. Was the baby blue or jaundiced?	[ ]	[ ]	_____

V. MEDICAL HISTORY

CONDITION	YES	NO		YES	NO
Frequent ear infections			Dizziness		
Frequent ear fluid			Heart disease		
Hearing problems			Loss of consciousness		
Allergies			Frequent sore throats		
Fainting			Prolonged fever		
Severe reaction to injection			Encephalitis		
Swallowing problems			Severe reaction to medication		
Drooling			Seizures/convulsions		
Dental problems			Neningitis		
Eye problems			Head trauma		
Asthma			Accidents		
Headaches			Poisoning/ingestions		
Breath holding spells			Low blood count/anemia		
Awkwardness			Excessive bleeding		
Weakness			Paralysis		
Muscle problems			Emotional problems		
Chronic cough			Tremors		
Bronchitis			Tingling in hands/feet		
Chronic diarrhea			Unusual walk, limp		
Slow weight gain			Chicken pox		
Kidney problems			Mumps		
Genital problems			Measles		
Joint problems			Scarlet fever		
Arthritis			Whooping cough		
Thyroid disease			Constipation		
Chronic skin problems			Long term separation		

VI . DEVELOPMENTAL PROFILE

A. At what age did you 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 sentences	_____ Button clothes
_____ Pedal tricycle	_____ Say own name	_____ Tie shoes
_____ Skip	_____ Use pronouns	_____ Know some letters

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

:	Yes	No	Comments
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	[ ]	[ ]	_____

VII. 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/"hyper"		
Substance usage			Acts like child of opposite sex		
Lies			Stubborn		
Fearless			Detention/Suspension		
Eats things that aren't food (dirt, paper, etc.)					

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

_____

_____

VIII. PARENTAL CONCERNS

Do you have current concerns about your child in any of the following areas?

	YES	NO		YES	NO
Has tantrums	☐	☐	Has trouble hearing	☐	☐
Is unable to accept limits	☐	☐	Favors one ear over other	☐	☐
Is aggressive	☐	☐	Has ear ached	☐	☐
Clings to an adult	☐	☐	Speaks loudly or softly	☐	☐
Rarely smiles, giggles, laughs	☐	☐	Watches speaker's face	☐	☐
Doesn't play with other children	☐	☐	Rubs ears frequently	☐	☐
Doesn't separate from me easily	☐	☐	Has eyes that turn in/out	☐	☐
Will not work in a group	☐	☐	Squints	☐	☐
Is left out of group activities	☐	☐	Favors one eye over other	☐	☐
Has toileting difficulties	☐	☐	Hold things close to see	☐	☐
Difficulty following routine	☐	☐	Rubs his/her eyes	☐	☐
Feeding and dressing difficulties	☐	☐	Blinks a lot	☐	☐
Is easily distracted	☐	☐	Has visual problems	☐	☐
Darts from one activity to another	☐	☐	Has unclear speech	☐	☐
Persists when asked to stop	☐	☐	Difficulty expressing wants	☐	☐
Is clumsy	☐	☐	Uses incomplete sentences	☐	☐
Difficulty buttoning/zipping	☐	☐	Needs instructions repeated	☐	☐
Eye/had coordination problems	☐	☐	Gives inappropriate answers	☐	☐
Poor control of body movement	☐	☐	Repeats what he/she says	☐	☐
Difficulty using crayons/scissors	☐	☐	Has very limited vocabulary	☐	☐
Difficulty writing letters	☐	☐	Is easily frustrated	☐	☐
Difficulty sitting through meal	☐	☐	Is extremely shy	☐	☐
Has unusual fears/nightmares	☐	☐	Demands attention	☐	☐
Can't tolerate change in routine	☐	☐	Frequently seems confused	☐	☐
Is very sensitive	☐	☐	Difficulty understanding what is said to him/her	☐	☐
Is stubborn	☐	☐			

Other concerns?

IX. ADDITIONAL INFORMATION

A. What types of group experiences has your child had? (e.g. daycare, preschool)

_____

B. Who cares for your child whe he/she is not with you? _____

C. What type of play activities does your child enjoy? _____

D. What is your child's favorite toy? _____

E. What is your child's favorite food? _____

Does your child have a regular mealtime routine? [ ] Yes [ ] No

F. How does your child get along with other children his/her age? _____

G. How does your child get along with brother(s)/sister(s)? _____

H. How does your child get along with parent(s)? _____

I. How does your child get along with other adults? _____

J. Is your child able to follow simple directions? (e.g. Get your book) [ ] Yes [ ] No

K. Does your child have a regular bedtime routine? [ ] Yes [ ] No

What time does your child go to bed? _____

Does your child sleep through the night? [ ] Yes [ ] No

L. With whom does your child spend most of his/her time? _____

Primary language spoken by this individual: _____

M. What kind of activities does your child attend to the longest? (e.g. TV, story, blocks):

_____

N. What after school activities does your child participate in? _____

O. What household responsibilities does your child participate in? _____

RELEASE OF INFORMATION PERMISSION

I hereby authorize the release of the information on this form to school, medical personnel or other agencies with a need to know.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

_____

SIGNATURE AND TITLE OF EVALUATOR DATE