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.

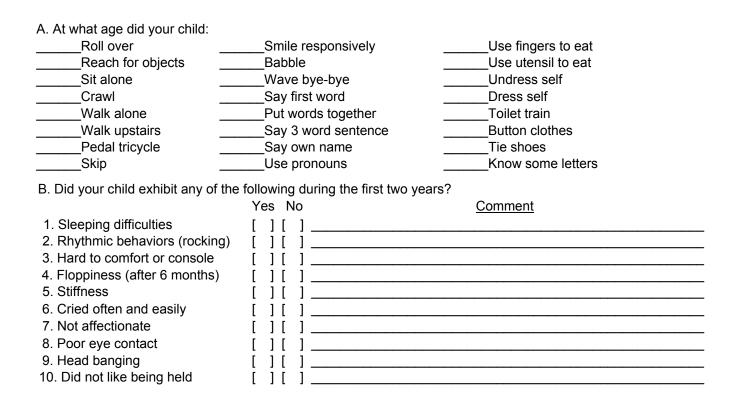
I. FAMILY INFORMATION

NAM	E:		GRADE	BIRTH DATE
SPONSOR'S				
Name:	Duty Phone		Home	Phone
SPOUSE Name:		uty Phone	Cell	Phone
If your child has had any of the	•	ous medical illnes	ses or problems, please ir	ndicate below.
Condition	Yes No			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 Weakness Muscle problems Chronic cough Bronchitis Chronic diarrhea Slow weight gain Kidney problems Genital problems Joint problems Arthritis Thyroid disease Chronic skin problems		Hear Loss Freq Prolo Ence Seve Seize Meni Head Accid Poise Low Exce Para Emo Trem Tingl Unus Chic Mum Meas Scar	tional problems hors ing in hands/feet sual walk ken pox hps	

III. PREGNANCY and BIRTH

A. List all preg	nancies (includ	ing miscarriages,	abortions, and li	ve births)	
Date	Length of	Birth	Outcome	Complications	
	Pregnancy	Weight		(Prolonged Hospital Sta	y)
	<u> </u>	<u> </u>			
<u> </u>		<u> </u>			
<u> </u>					
	ake any medicat		egnancy?[]Ye	child who is being evaluated. es [] No)
2. Did you sr	moke cigarettes	during the pregn	ancy? []`	Yes []No	
•		ng the pregnancy		Yes []No	
•	se any illegal dr a planned pregr	ugs during pregn		Yes []No Yes []No	
		•			
6. Did any of	Yes No	ccur during the p	Yes	No Ye	s No
Fever Spotting Diabetes Toxemia Surgery Amniocentesis Asthma	[][] [][] [][] [][] s [][]	Kidney infection Threatened mis Sugar/protein in RH factor probl	[] scarriage [] n urine [] em [] izures []	[]German measles[[]Vaginal bleeding[[]Morning sickness[[]Special diet[[]Accident/injury[[]Pre-term labor[) []] []] []] []] []] []] []
7. How long w	as labor?		·····		
8. How was th	e baby delivere	d? []Vagir	na []C-sec	tion [] Forceps/Vacu	um assist
C. Infant's Co	ndition at Birth				
Birth weight: _	Ler	igth:	_Head circumfere	ence:APGAR sc	ores:
		Yes No			Yes No
Breathed imm Cried immedia Resuscitation Was jaundice Was blue	ately required	[] [] [] []		Had seizures or convulsions Had infection Had skin rash Had bleeding problem Had low blood sugar	
D. Procedure	s or treatments	use with infant:			
		Yes No			Yes No
Fluids by nee Transfusion Oxygen thera Special lights Medication	ру	[][] [][] [][] [][] [][]		Feeding by tube Incubator Breathing machine Chest tubes Antibiotics for infection	[][] [][] [][] [][] [][]

IV. DEVELOPMENT PROFILE



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	Child's	Child's	Father's	Mother's
	Children	Father	Mother	Family	Family
1. Depression /Psychiatric	[]	[]	[]	[]	[]
2. Alcohol problems	[]	[]	[]	[]	[]
Drug problem	[]	[]	[]	[]	[]
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	[][]
ls 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 sex	D[][]
Lies	[][]	Eats things that aren't	[][]
Fearless	[][]	food (dirt, paper, etc.)	

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