

INITIAL HEALTH AND DEVELOPMENTAL HISTORY

Ventura County SELPA

School Nurse: _____ Date: _____

Information obtained from: _____

Student Name: _____ Grade: _____

I.D.#: _____ B.D.: _____ C.A.: _____ Yrs. _____ Mo. School: _____

Address: _____ Phone: _____
(Street & Number) City Zip

I. FAMILY:

Mother's Name: _____

Father's Name: _____

Parent/Guardian's statement of reason for this school study: _____

How frequently does the student see each parent? _____

Any siblings in special education? _____

II. ANY SIGNIFICANT MEDICAL PROBLEMS IN THE FAMILY? (Include immediate family and grandparents)

III. OBSTETRICAL: Prenatal Care Began at _____ months RH Factor Problem _____

Mother gained _____ pounds.

Did mother have any of the following conditions during pregnancy? If yes, please give the gestation month(s).

- | | | | |
|---------------------|--|-----------------------|--|
| Rubella | <input type="checkbox"/> No <input type="checkbox"/> Yes | Toxemia of Pregnancy | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| High Fevers | <input type="checkbox"/> No <input type="checkbox"/> Yes | Accidents (Injuries) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Bleeding | <input type="checkbox"/> No <input type="checkbox"/> Yes | Excessive Vomiting | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hospitalization | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Edema | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Specific Illness | <input type="checkbox"/> No <input type="checkbox"/> Yes | Unusual Life Stresses | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Explain: _____

Medication during pregnancy? No Yes
Types and frequency of use: _____

Substance during pregnancy? No Yes
Types and frequency of use: _____

IV. DELIVERY: Birth weight: _____ Premature: _____ Months Gestation: _____

Duration of labor: _____ hours Type of delivery: Vaginal Cesarean Special Cesarean

Presentation: Head Breech Other: _____

Anesthetic used was: _____

Apgar (if known): _____

History of fetal distress: _____

Description of any problem: _____

V. **DEVELOPMENTAL:** (Age of occurrence, month and/or year)
Sat Alone: _____ Toilet Training: _____
Walked Alone: _____ Unusual Activity Level: _____
Speech Delays: _____

Consistent use of first words: _____
Any destructive behaviors (describe): _____
Type of childcare first 3 years: _____

VI. **STUDENT'S MEDICAL HISTORY:**

Frequent upper respiratory infection: _____ Headaches: _____
Prolonged high fevers: _____ Dizziness: _____
Chronic GI disturbances: _____ Present hours sleep/night: _____
Any skill or speech loss: _____ Menses: _____
Describe: _____
Asthma? No Yes Severity _____ Triggers: _____
Medications: _____
Allergies? No Yes Type: _____ Severity: _____ Medication: _____
Ear infections: No Yes Duration: _____ From age: _____ to _____ Frequency: _____
Hearing tests and hearing difficulties if known: _____
Myringotomy and tube insertion: Dates: _____
Seizures? No Yes When did they occur: _____
Medication: _____
Counseling: No Yes Reason: _____
Duration: _____ Frequency of sessions: _____
Does your child have any other medical conditions such as cerebral palsy, diabetes, A.D.D. or chronic health problems, etc? _____
Describe: _____
Current medications: _____

Dates/Details

Head injuries No Yes _____
Serious accidents No Yes _____
EEG and/or X-Ray/MRI No Yes _____
Serious Illness/Surgery No Yes _____

Name and address of student's primary physician: _____

Other medical specialists seen: _____

VII. **HEALTH DATA:**

Height: _____ Growth %ile: _____ Weight: _____ Growth %ile: _____
Vision screening date: _____ Passed Failed Glasses: Yes No Acuity: _____
Other vision information: _____
Hearing screening date: _____ Passed Failed
Other hearing information: _____

VIII. **OTHER INFORMATION:**

Attendance: Excellent Good Fair Poor
Average hours of TV viewing per week: _____
Usually frequent visits to the school health office: No Yes
Chief Complaint (s): _____

IX. **HEALTH/PHYSICAL STATEMENT:** (Including vision and hearing)

X. **SCHOOL NURSE'S STATEMENT OF EDUCATIONALLY RELEVANT MEDICAL CONDITIONS:**
 No Yes Specify:

XI. **ANY ADDITIONAL INFORMATION:**