SAN JUAN UNIFIED SCHOOL DISTRICT - Health Services Department

HEALTH AND DEVELOPMENTAL INFORMATION

The purpose of this form is to identify problems that may affect learning for your student. You may choose not to answer any question.
The school nurse is available to help you by phone: _____

STUDENT: _____ BIRTHDATE: _____ SEX: ___ GRADE:_____
SCHOOL: _____ TEACHER: _____
Person providing history: _____ Relationship to student: _____
Preferred phone: _____ Alternate phone: _____ Best time to call: _____
Language spoken: _____

PRENANCY/BIRTH HISTORY:

Birth weight: _____ Full term: □Yes □No If no, age in weeks at birth: _____ □ Vaginal delivery □ C-Section
If C-Section, please explain: _____
Month of pregnancy that prenatal care began: _____
Were there any problems during the pregnancy? □Yes □No _____
Medications/alcohol/drugs/tobacco taken during pregnancy? □Yes □No _____
Any problems for mother or baby during/after delivery? □Yes □No _____
Did baby have to stay in hospital/receive special care after birth? □Yes □No _____
Any feeding difficulties in infancy? □Yes □No _____

DEVELOPMENTAL HISTORY:

At what age did the child do the following? Sit alone ____ Stand alone ____ Crawling ____ Walk alone ____ Speak first words ____
Speak in Sentences ____ Toilet trained ____ Are you, or has anyone, ever been concerned about the student's development? □Yes □No
If Yes, explain: _____
Has the student ever received any physical, occupational, speech or language therapy? □Yes □No
If Yes, explain: _____

HEALTH HISTORY:

Has the student had a problem in the following areas? If YES, please provide details below.

Head injury	□Yes □No	Nerve or muscle disease	□Yes □No
Frequent/severe headaches	□Yes □No	Heart problems	□Yes □No
Ear/Hearing problems	□Yes □No	Eating/Stomach/Intestinal problems	□Yes □No
Eye/Vision problems	□Yes □No	Urinary/digestive/bowel problems	□Yes □No
Convulsions/Seizures	□Yes □No	Diabetes	□Yes □No
Oral/dental problems	□Yes □No	Skin problems	□Yes □No
Asthma/Breathing problems	□Yes □No	Surgery (reason/age)	□Yes □No
ADD/ADHD	□Yes □No	Serious accidents or Fractures/stitches	□Yes □No
Autism/Asperger's	□Yes □No	(location/age) _____	
Emotional disturbance	□Yes □No	Genetic Disorder	□Yes □No
Psychiatric Care	□Yes □No	Other health concerns/serious	
Back/Spine/extremity problems	□Yes □No	illnesses/Hospitalizations	□Yes □No

If any of the above are marked "Yes", please explain and give age of student at problem onset/diagnosis (attach another page if necessary):_____

_____

List any other diagnosis, syndrome or disability the student has or has had in the past. (List condition, treatment, who diagnosed, when, etc): _____

_____

Family History

Is there anyone in the family who had learning problems? □Yes □No If Yes, please describe: _____
Is there anyone in the immediate family with a serious medical problem (heart, diabetes, cancer, etc?) _____

PLEASE CONTINUE ONTO PAGE TWO →

Behavioral History:

Describe any concerns you have about the student's behavior: _____

Does the student currently have any emotional or behavior problems? □Yes □No If Yes, please describe (include if student is currently receiving therapy/counseling): _____

_____

Current Medical History

How would you describe the student's current general health? □ Good □ Fair □ Poor Comment _____

Current or chronic health problems/limitations? _____

_____

Does the student have any allergies (food, medications, environmental, etc)? □Yes□No If yes, please describe allergy and reaction:

_____

Are the allergies life threatening? □Yes □No Has the student ever experienced anaphylaxis? □Yes □No If yes, when and what were the circumstances? _____

Is the student taking medication now (Including prescribed, over the counter, herbal, other remedies)? □Yes □No.

If yes, list name, dose, how often, and reason for medication: _____

_____

Nutrition

Current Height: _____ Weight: _____ Females: Age of onset of menstruation _____ Any problems? _____

□ WIC □ Supplements/Fe □ Formula/Type_____ □ G Tube Feedings If so, times _____ Dietary Restrictions? _____

Primary Healthcare Provider (Name): _____ Phone: _____

Does the student currently have health insurance? □Yes □No Insurance: _____

Does the student see a healthcare provider regularly? □Yes □No Date of last physical exam: _____

Please list any other specialists: _____ Last visit/reason: _____

List any county/community agencies from which the student is receiving services: _____

Dental Care Provider (Name):_____ Phone: _____

Does the student currently have dental insurance? □Yes □No Date of last visit/reason: _____

Eye Care Provider (Name): _____ Phone: _____

Wear glasses/contacts now? □Yes □No Date of last prescription:_____

Does the student currently have vision insurance? □Yes □No Last visit/reason: _____

Describe any eye problems:_____

Sleep Number of hours sleep student gets most nights? ____ Normal bedtime: _____

Student has usual bedtime routine? □Yes □No Student wakes up rested? □Yes □No

Student falls asleep easily? □Yes □No Student's sleep is: □ restful □ restless

Student: □ Snores □ wets pants/bed □ has other sleep issues Explain: _____

How many days of school has the student missed this year? _____ Are any of these days due to health reasons? □Yes □No.

If Yes, please explain: _____

Are there other factors that you feel the school should be aware of concerning the student (such as frequent family moves, divorce, etc.)?

_____

Is the student currently receiving Special Education services (or has in the past)? □Yes □No If yes, please describe what services and age: _____

Is there anything else you would like to discuss with the School Nurse? □Yes □No If yes, explain: _____

_____

_____

SIGNATURE: _____ DATE: _____