Date _____

Medical History Form

** The Medical History gathered by a school nurse is not intended to make a diagnosis. The nurse gathers information from outside agencies and parents to determine if there are specific syndromes, health concerns, medication and any information deemed necessary for planning the student's education program. This form is completed as part of a COMPREHENSIVE and INDIVIDUAL EVALUATION to determine IDEA Eligibility. Your answers to the questions below will be helpful in planning your child's school program. Only authorized school personnel working with your child will review this form.

Student's Full Name _____

Student's Gender: ____ Male ____ Female DOB: _____ Grade: _____

This form was filled out by: _____

via: ____ phone interview ____ translator ____ in person meeting

____ form completed by guardian and later reviewed by RN

The relationship between the person answering these questions and the student:

____ Biological Parent ____ Grandparent ____ Step Parent ____ Other (please specify)

____ Foster Parent (please list the year custody was established _____)

____ Adoptive Parent (please list the year custody was established _____)

Family History

Indicate whether any member of the ***child's IMMEDIATE biological family*** (i.e., parents and siblings) experienced any of the following. Please check all that apply:

☐ ***Not applicable- no family history of any of these conditions***

Difficulty	Relationship to Child	Difficulty	Relationship to Child	Difficulty	Relationship to Child
☐ Autism Spectrum Disorder		☐ Compulsive Behaviors		☐ Intellectual Disability	
☐ Anxiety		☐ Obsessive Behaviors		☐ Learning Disability	
☐ Inattention		☐ Bipolar Disorder		☐ Special Education	
☐ Hyperactivity		☐ Depression		☐ Epilepsy	
☐ Language Delays		☐ Schizophrenia		☐ Cerebral Palsy	
☐ Speech Disorder		☐ Tics		☐ Seizures	
Other family history not listed above:					

Pregnancy/ Birth History

Please mark any unusual pregnancy/labor issues:

☐ ***Not applicable- no unusual pregnancy/birth issues***

☐ fetal drug/alcohol exposure	☐ birth trauma
☐ abnormal blood loss	☐ NICU stay (include reason)
☐ preterm labor	☐ oxygen given
☐ elevated temperature or infection	☐ other concerns (specify)

Developmental Milestones

Please check whether your child ever had a delay in reaching normal child development? (i.e. walking, talking, social interactions, gross or fine motor skills, difficulty understanding or following instructions.)

☐ ***Not applicable- no developmental delays***

Motor Milestone Delays:	**Age Acquired:**	**Speech/Language Milestone Delays:**	**Age Acquired:**
☐ sitting up		☐ smiling	
☐ crawling		☐ social interactions	
☐ independent walking		☐ first words	
☐ independent toileting		☐ 2-3 words paired	
☐ difficulty understanding and following directions		☐ other delays (specify)	

History of Serious Illness, Accidents/Injuries, or Hospitalizations

Please list any serious illnesses, accidents, injuries, or surgeries (including head injuries, traumatic incidents, any loss of oxygen, multiple surgeries for ear tubes, etc.)

☐ ***Not applicable- no history of illnesses, accidents/injuries, or hospitalizations***

Illness/Injuries/Hospitalizations	**Date or Age**	**Required treatment (i.e. surgery, medication, therapy, rehab., etc.)**

Diagnosed Conditions

Check the box if your child has been diagnosed or experienced any issues related to a specific condition or a particular body system and describe the problem below.

☐ ***Not applicable- my child does NOT have any diagnosed conditions***

☐ ADD/ADHD	☐ Behavioral	☐ Traumatic Brain Injury	☐ Musculoskeletal
☐ Autism	☐ Conduct Disorder	☐ Seizure Disorder	☐ Autoimmune
☐ Anxiety	☐ Oppositional Defiant Disorder	☐ Neurological	☐ Endocrine
☐ Depression	☐ Disruptive Mood Dysregulation Disorder	☐ Gastrointestinal/Genitourinary	☐ Genetic/Chromosomal
☐ PTSD/Trauma	☐ Speech/Language Disorder	☐ HEENT (Head, Ears, Eyes, Nose, Throat)	☐ Lymphatic
☐ Other Mental Health	☐ Developmental Delay	☐ Other (specify)	

If you checked a diagnosis above, please provide the name of the health care provider(s) that issued the diagnosis.

Please give additional details about the above diagnosed conditions- name of the condition, year or age diagnosed, and the current treatment (i.e. medications, therapies, devices).

Current Medications (Please list the name of the medication, dose, frequency, and what it was prescribed for):

☐ ***Not applicable- my child does not currently take any medications***

Therapy

Has your child ever received therapy or help from any school, community or private agencies? Please list the therapy and the company. (i.e. ABA therapy, physical therapy, occupational therapy, speech, counseling, etc.)

☐ ***Not applicable- my child has never received any type of therapy***

Devices

Does your child use any special equipment or technology to improve functioning?

☐ ***Not applicable- my child does not use any devices***

Does your child have difficulty falling asleep? Staying asleep? Frequent disruptive sleep patterns? Please describe.

☐ ***Not applicable- no sleep difficulties***

Does your child wear glasses? ___ Yes ___ No
If yes: ___ Distance only ___ Reading only ___ Wears Continually

Please list below if your child has any current or past behavior issues/tendencies:

What concerns you most about your child's education (e.g. behavioral, academic, social, language)?

Please describe your child's personality and strengths:

Is there anything else you would like us to know about your child's health or medical needs?

**This Medical History has been reviewed and signed by a Registered Nurse employed by Weber School District. This information will be reviewed by the authorized personnel during the Special Education Eligibility process. This form is comprehensive to the best of my knowledge.

Reviewed by RN: _____ Date: _____