**FOUR RIVERS SPECIAL EDUCATION DISTRICT**

**MEDICAL HISTORY AND CURRENT HEALTH STATUS**

The following information is required as a component of a Comprehensive Case Study Evaluation. Complete with as accurate information as available. When completing the form to up-date information, complete only the identifying information, the sections on Vision/Hearing Tests and Current Health Information, and the Summary. Significant health concerns may require that an additional page be added.

Initial Up-Date

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation of Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_District\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_\_

## DEVELOPMENTAL HISTORY

Significant health problems during pregnancy or delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During what part of pregnancy? \_\_\_\_\_\_First\_\_\_\_\_\_Second\_\_\_\_\_\_Last Birthweight?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Term?\_\_\_\_\_\_\_\_\_\_\_Premature?\_\_\_\_\_\_\_\_\_\_\_Received Oxygen?\_\_\_\_\_\_\_\_\_\_\_Failure to Thrive?\_\_\_\_\_\_\_\_\_\_\_

Was the delivery \_\_\_\_\_\_Normal\_\_\_\_\_\_Breech\_\_\_\_\_\_Caesarian? Was anethesia used?\_\_\_\_\_\_yes\_\_\_\_\_\_no

How long was labor?\_\_\_\_\_\_Known injuries or defects\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sit alone\_\_\_\_\_\_ Stand alone\_\_\_\_\_\_Age walked\_\_\_\_\_\_Age dry day and night\_\_\_\_\_\_

Spoke words\_\_\_\_\_\_Use real words\_\_\_\_\_\_Talked in sentences\_\_\_\_\_\_

Describe the child's speech now?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Feeding problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe child’s general behavior\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISEASES AND ILLNESSES** (Please give dates)

Chickenpox\_\_\_\_\_Scarlet Fever or Scarletina\_\_\_\_\_Pneumonia\_\_\_\_\_Rheumatic Fever\_\_\_\_\_Red Measles\_\_\_\_\_\_

Ear Infections\_\_\_\_\_StrepInfection\_\_\_\_Epilepsy\_\_\_\_Tonsilitis\_\_\_\_Meningitis\_\_\_\_Hepatitis\_\_\_\_Other\_\_\_\_

## LEAD SCREENING

## Passed\_\_\_\_\_\_\_\_\_\_ Failed\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

If failed, explain follow-up\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY** (Indicate relationship to student)

Tuberculosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Epilepsy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bleeders\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rheumatic Fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speech\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emotional Illness\_\_\_\_\_\_\_\_

Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardiac\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other family health concerns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Remarks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### CURRENT HEALTH INFORMATION

Date of Last Physical Examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Constipation or Diarrhea \_\_\_\_Allergies \_\_\_\_Asthma \_\_\_\_Fatigue

\_\_\_\_Eye Strain or Difficulty Seeing \_\_\_\_Ear Infection \_\_\_\_Aches & Pains \_\_\_\_Frequent Colds

\_\_\_\_ADHD or ADD \_\_\_\_Unusual Eating \_\_\_\_Sleep Problems \_\_\_\_Convulsions

Patterns

\_\_\_\_Other

If yes to above, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Surgery or serious illness or accident?\_\_\_\_\_\_\_\_\_\_Describe and give age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List current medication, dosage and how long\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childhood diseases and illness contracted within the last three years which are not indicated earlier in this report\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Changes in family medical history which might impact upon the student and which are not included in Family Medical History above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other health concerns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# SUMMARY AND INTERPRETATION OF MEDICAL HISTORY

# AND CURRENT HEALTH STATUS

Comment on the impact of health history and status on how child functions in an educational setting.

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### VISION AND HEARING

Has the child ever had tubes in his/her ears?\_\_\_\_\_\_yes\_\_\_\_\_\_no If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Screening Passed\_\_\_\_\_\_\_\_\_\_ Failed\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Hearing Screening Passed\_\_\_\_\_\_\_\_\_\_ Failed\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

If failed, explain follow-up\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who performed the screening/audiological?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunizations (Up-to-date?) Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

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Source of Information Interviewer/Title Date