

# HEALTH INFORMATION (Required prior to Tier I Meeting)

## Parent Contact

Student/ID # \_\_\_\_\_

Referring Staff Member/Position \_\_\_\_\_

Date \_\_\_\_\_

**NOTE: NURSE HAS 5 WORKING DAYS TO COMPLETE FORM**

INTERVIEWER: \_\_\_\_\_ RN: \_\_\_\_\_ LVN: \_\_\_\_\_ DATE RECEIVED: \_\_\_\_\_

### HEALTH SCREENING

Student: \_\_\_\_\_ DOB: \_\_\_\_\_

HT. \_\_\_\_\_ WT. \_\_\_\_\_ FOC \_\_\_\_\_ B/P \_\_\_\_\_ BMI \_\_\_\_\_

% \_\_\_\_\_ % \_\_\_\_\_ % \_\_\_\_\_ % \_\_\_\_\_ % \_\_\_\_\_

### VISION & HEARING

Distance Visual Acuity: \_\_\_\_\_

Results without glasses: right 20/ \_\_\_\_\_ left 20/ \_\_\_\_\_

Results with glasses: right 20/ \_\_\_\_\_ left 20/ \_\_\_\_\_

Results: \_\_\_\_\_ Pass \_\_\_\_\_ Fail /Date: \_\_\_\_\_

Near Visual Acuity: \_\_\_\_\_

Results: \_\_\_\_\_ Pass \_\_\_\_\_ Fail /Date: \_\_\_\_\_

Type of hearing screening: \_\_\_ Sweep audiometry  
\_\_\_ Threshold audiometry \_\_\_ Other \_\_\_\_\_

Results: \_\_\_ Pass \_\_\_ Fail/Date: \_\_\_\_\_

Person conducting Screening(s): \_\_\_\_\_

Position: \_\_\_\_\_

### HISTORY OF PREGNANCY

Age of mother at birth of student: \_\_\_\_\_

Presence of the following during pregnancy:

1. Bleeding \_\_\_ Yes \_\_\_ No

2. X-rays \_\_\_ Yes \_\_\_ No

3. Illness \_\_\_ Yes \_\_\_ No

Specify: \_\_\_\_\_

4. Medications \_\_\_ Yes \_\_\_ No

5. Diabetes \_\_\_ Yes \_\_\_ No

6. Accidents \_\_\_ Yes \_\_\_ No

7. Surgery \_\_\_ Yes \_\_\_ No \_\_\_ No

Full Term \_\_\_\_\_ Premature \_\_\_\_\_

Birth weight: \_\_\_\_\_

Were there any problems before, during, or immediately  
After birth? \_\_\_ Yes \_\_\_ No

### STUDENT'S DEVELOPMENTAL HISTORY

Sat at \_\_\_ months Walked at \_\_\_ months

Talked at \_\_\_ months

Comparisons with brothers, sisters, or other children  
at about the same age:

\_\_\_\_\_ About the same \_\_\_\_\_ Slower \_\_\_\_\_ Faster

Does anyone in the family have conditions similar  
to those of the student? \_\_\_ Yes \_\_\_ No

Is there a history in the family of:

Learning or reading disorder: \_\_\_ Yes \_\_\_ No

Mental retardation: \_\_\_ Yes \_\_\_ No

Emotional illness: \_\_\_ Yes \_\_\_ No

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date Completed: \_\_\_\_\_

### STUDENT'S GENERAL HEALTH & MEDICAL HISTORY

Briefly describe any serious illnesses, accidents or hospitalization.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the child have physical or health problems? \_\_\_ Yes \_\_\_ No If **Yes**,  
please explain: \_\_\_\_\_

Is your child under the care of a physician? \_\_\_ Yes \_\_\_ No If **Yes**, please  
explain: \_\_\_\_\_

Is your child taking any medicines? \_\_\_ Yes \_\_\_ No If **Yes**, please  
explain: \_\_\_\_\_

Has your child ever taken medicine for a long period of time? \_\_\_ Yes \_\_\_ No  
If **Yes**, please explain: \_\_\_\_\_

Does your child appear to have any side effects from the medicine? \_\_\_ Yes  
If **Yes**, please explain: \_\_\_\_\_

Does your child use any special equipment or technology? \_\_\_ Yes \_\_\_ No If  
**Yes**, please explain: \_\_\_\_\_

Is your child receiving services from another agency? \_\_\_ Yes \_\_\_ No If **Yes**,  
please explain: \_\_\_\_\_

### FURTHER ASSESSMENT

As a result of health screening, is there indication of a need for further  
assessment of vision, hearing or general health? \_\_\_ Yes \_\_\_ No If **Yes**,  
please explain **problem/concern**:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note:** Referral to a health care provider must be accompanied by results of  
screening tests.