

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.