San Diego Unified SCHOOL DISTRICT

Nursing & Wellness

COMPLETE HEALTH & DEVELOPMENTAL HISTORY

Student: _____ Birthdate: _____ Today's Date: _____

Person completing form: _____ Relationship: _____

Preferred phone number: ( ) _____ Email: _____

Current Primary Physician:_____ Phone: ( )_____

Other Physician(s):_____ Phone: ( )_____

Current counselor/therapist (if applicable) _____ Phone: ( ) _____

Name of health insurance: _____ ☐ None ☐ I would like assistance obtaining insurance

My child wears glasses or contact lenses for: ☐ Distance ☐ Reading ☐ Constant Last eye exam (date)_____

Does your child have a history of frequent ear infections, tubes, or other hearing problems? _____

Does your child have any dental problems? _____ Date of last dental exam _____

How many meals does your child eat daily? _____ How many servings of milk daily? _____

Does your child need a special diet? If yes, please specify _____

Does your child eat a variety of foods (fruits, vegetables, meat, etc.)? _____

Do you have any concerns about your child's nutrition? _____

Normal school night bedtime _____ PM Normal weekend bedtime _____

Normally awakens at _____ AM ☐ on own ☐ with alarm clock ☐ by parent/guardian

My child has ☐ no sleep problems ☐ difficulty falling/staying asleep ☐ difficulty waking up ☐ frequent nightmares

Does your child participate in organized sports? _____

Is your child active outside of school? _____ Any activity restrictions? _____

Has your child ever had a concussion or needed to be monitored because of a head injury? ☐ Yes ☐ No

If yes, please explain _____

Do you have concerns about your child's activity level? ☐ Yes _____ ☐ No

Please list your child's extracurricular activities (scouts, music lessons, clubs, etc.) _____

Average # of hours per day spent on computer _____ video games _____ watching TV _____

Did your child repeat or have difficulty with a grade? ☐ Yes - grade(s) _____ ☐ No

Has your child missed a lot of school? ☐ Yes - reason_____ ☐ No

How many schools has your child attended? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6

Please list all people living in the household with student

Name	**Relationship to student**	**Age**	If this person has any medical, emotional, or learning problems, please specify

Do you have concerns about alcohol, bullying, drugs, sexual activity, or smoking for your child? _____

My child consistently wears: ☐seatbelt ☐sunscreen ☐helmet ☐protective gear

Did the mother have any medical problems during the pregnancy? ☐ Yes-_____ ☐ No
Mother took ☐ medication-_____; ☐ alcohol; ☐ drugs -_____; ☐ cigarettes; ☐ none
Is it possible that mother consumed alcoholic beverages before she knew she was pregnant? ☐ Yes ☐ No
Was the pregnancy difficult in any way? ☐ Yes- _____ ☐ No
Was the labor/delivery difficult? ☐ Yes-_____ ☐ No

Delivery: ☐vaginal ☐ forceps ☐ vacuum ☐ C-section ☐ scheduled ☐ emergency ☐ failure to progress
Baby was: ☐ full term ☐ premature _____ weeks gestation ☐ overdue by _____ weeks
☐ Single ☐ Twin ☐ Triplet ☐ Other _____ Baby's birth weight _____ lbs _____ oz
Were there any birth defects? ☐ Yes - _____ ☐ No
☐ Meconium ☐ Apnea ☐ Breathing problems ☐ Needed oxygen ☐ Jaundice
☐ Needed incubator ☐ Feeding problems Was child breast-fed ☐ Yes (how long _____) ☐ No
Did the baby go home from the hospital with the mother? ☐ Yes ☐ No, because _____

Developmental History

(average age in parenthesis)	Early	Average	Late	(average age in parenthesis)	Early	Average	Late
Sat alone (6-11 months)	☐	☐	☐	Crawling (6-10 months)	☐	☐	☐
Spoke first word (9-13 months)	☐	☐	☐	Walked alone (11-15 months)	☐	☐	☐
Put words together (15-28 months)	☐	☐	☐	Toilet trained (24-36 months)	☐	☐	☐

Medical History

Concern or Diagnosis	Never had	Used to have	Currently has	Details
Accidents				
ADHD				
Anemia				Type:
Anxiety				
Arthritis				
Asthma				
Behavior				
Bladder/kidney				
Bleeding disorder				
Bowel/bladder control				
Broken bones				
Cancer				
Depression				
Diabetes				
Drug/Alcohol/Tobacco use				
Emotional				
Eyes/Vision				
Fainting episodes				
Gastrointestinal				
Headaches/Migraines				
Hearing				
Heart/Cardiac				
High Fevers				
Menstruation				
Muscular				
Neurological				
Orthopedic				
Respiratory/Frequent colds				
Seizures				
Self-injury (i.e., cutting)				
Serious head injury				
Skin problems/rashes				
Snoring				
Speech				
Suicidal thoughts or attempts				
Thyroid (hypo / hyper)				
Other				

Is your child known to any community agencies (CCS, Regional Center, etc.)? ☐ Yes - _____ ☐ No

Please list current medical & psychiatric diagnoses below, or check ☐ ***NONE***

Diagnosis	Date of diagnosis	Name of treating doctor/clinic

Please list current medications below, or check ☐ ***NONE***

Name of medication	Prescribed for (e.g., asthma, allergies, ADHD, seizures)	Dose (mg, puffs)	When taken (morning, as needed, twice a day, bedtime)

Please list known allergies (environment, food, insect, medication, etc.) below, or check ☐ ***NONE***

Allergic to:	Reaction (runny nose, itchy, hives, rash, trouble breathing, vomiting, etc.)

Additional Comments or Concerns

Please list any other information you believe is important for us to know about your child to best serve his/her needs and any other concerns you have about your child's health, nutrition, vision, hearing, dental, etc.

**Please complete the reverse side of this page and return to the school nurse **

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOLS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____

Last **First** **MI** **Date of Birth**

I, the undersigned, do hereby authorize (name of health care provider, health plan and/or agency):

_____ _____

to provide health information from the above-named child's medical record to and from:

_____ _____

School to Which Disclosure is Made **Address / City and State / Zip Code**

_____ _____

Contact Person at School District **Telephone and Fax Number**

Disclosure of health information is required for the following purpose: _____

Requested information shall be limited to the following:

☐ All minimum necessary health information; **or** ☐ Disease-specific information as described: _____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ **(enter date)** or for one year from the date of signature, if no date entered.

RESTRICTIONS:

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

PARENT/GUARDIAN RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

STUDENT RIGHTS:

Students between the ages of 12 and 18 years must sign this form in order to approve the disclosure of information relating to mental health and family planning issues.

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

Parent Printed Name	Parent Signature	Date
Relationship to Patient/Student	Area Code and Telephone Number	
Student Printed Name	Student Signature	Date