Pasadena Independent School District

Student Health History Provided by School Nurse

Student____ **ID#**_____________________ **DOB**_____________________

I. Vision Screening Results:

Date Tested: __________________________________ Screening Tools: _______________________________

Acuity: Without correction Right: _______________ Left: _______________ Both Eyes: _______________
With correction Right: _______________ Left: _______________ Both Eyes: _______________

Near Vision: Right: _______________ Left: _______________ Both Eyes: _______________

Muscle Balance: ________________________________

Student is unable to be tested using standard vision screening procedures. A gross vision screening indicates:

Can see 1 inch object on floor	yes	no
Can identify 1 inch objects by color at about 2 feet	yes	no
Can name common 1 inch objects as displayed at 2 feet	yes	no
Can follow source of light with eyes	yes	no

Was referral made? _____ Yes _____ No Date: ____________________
Results: ____

II. Hearing Screening Results:

Date Tested: __________________________________ Screening at: _______________________________

Tympanogram: _____ Yes _____ No Results: Right: _______________ Left: _______________

Student is unable to be tested using standard hearing screening procedures. A gross hearing screening indicates:

The student responds to own name spoken in conversation	yes	no
Turns toward sound of coin dropped behind him/her	yes	no
Responds to ringing of soft hand bell	yes	no
Exhibits response (startle reflex) to sudden loud noises behind him	yes	no

Was referral made? _____ Yes _____ No Date: ____________________
Results: ____

Nurse does parts I and II before the Informal Assistance Team Meeting Phase I and completes the form for Phase III

III. Health History (Please contact parent(s) to obtain the following information)

Country where student was born______________________________

Mother's age at the time of student's birth______________________

Did mother receive prenatal care?________ If no, explain____

Did mother take any prescribed medications during pregnancy?_______ If yes, explain___________________________
____

Were any other substances used during pregnancy, such as cigarettes, alcohol, etc?______________________________

Did the mother experience any medical complications, serious illnesses, or accidents during the pregnancy?__________ If yes, explain____

Did the student experience any health complications at or following birth or during infancy?________ If yes, explain____

Student____

Has the student ever been seriously ill, seriously injured, or hospitalized?_______ If yes, explain
____

Has the student had any of the following:

___ Asthma
___ Allergies
___ Ear Infections
___ Respiratory Infections
___ Heart Problems
___ Kidney Problems
___ Head Injury
___ Vision Problems
___ Convulsions
___ High Fevers
___Other:_______________________________

Significant information related to treatment of the above conditions ____
____

Has the student been diagnosed by a medical doctor or licensed psychologist with any of the following conditions?

___ Down's Syndrome
___ Fragile X
___ ADHD
___ Blindness
___ Deafness
___ Developmental Delay
___ Prader-Willi
___ Seizure Disorder
___ Cerebral Palsy
___ Tourette's Syndrome
___ Spina Bifida
___ Pervasive Developmental Disorder
___ Autism
___ Fetal Alcohol Syndrome
___ Depression

Is the student currently under a doctor's care for any health problem?______ If yes, explain______________________
____

Does the student take prescribed medication ____ at school? ____ at home?

If yes, what medication(s)?____

For what reason(s)? ____

When is the medication given? ____

How long has the student been taking the medication? ____

IV. School Health Information:

If the student is to take prescribed medication, is it being taken consistently? If no, explain ________________________
____

Does the student have a history of chronic illness or complaints that necessitate clinic visits? _____ Yes _____ No

If yes, explain: ____
____

Does the student require other ongoing health services such as those listed below?

If yes, check the blank(s):

_____ special prescribed diets
_____ catheterization
_____monitoring use of wheelchair, crutches, etc.
_____ special feeding procedures
_____ monitoring of seizures
_____ prescribed rest periods
_____ other: ____

Are there any medical restrictions for this student for physical education? _____ Yes _____ No

If yes, explain: ____
____

Additional Information:
____
____

Nurse's Signature____ **Date Completed** ______________________________