



LEYDEN AREA SPECIAL EDUCATION COOPERATIVE

10401 GRAND AVE., FRANKLIN PARK, IL 60131

PHONE: 847-455-3143 FAX: 847-451-4892

Michael T. McElherne, Ed.D.

Director

HEALTH HISTORY

Name of Student (L,F,M): Birthdate

Information for this health history should be secured from a parent or guardian during a personal interview conducted by the home school's nurse, health clerk, or other qualified individual designated by the principal. Please attempt to secure as much information as possible.

A. Family History (Please indicate relationship to student.) Epilepsy Diabetes Heart Condition Allergies Chronic Illness Visual Defects Hearing Defects Emotional Illness Mental Impairment

B. Mother's Pregnancies Full Term Stillborn Premature Miscarriages Student's number in order of birth Illnesses during pregnancy with student (list month of pregnancy and treatment used)

Medications consumed by mother during or prior to pregnancy

Medications consumed by father prior to conception of student

Does mother smoke? Does father smoke? Other members of household? Attending Physician Mother's age at birth of student Student's condition at birth Birth Weight Type of delivery Length of labor Medical attention needed (describe):

C. Developmental History (List age) Turn over alone Sat alone Crawled Stood alone Walked Toilet trained Hand preference Bed wetter If yes, to what age? Feeding Problems Allergies

Special attention needs

Student Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

D. Speech

List age spoke first word \_\_\_\_\_ Sentences \_\_\_\_\_

Speech problems (describe) \_\_\_\_\_

Bilingual background (other language spoken) \_\_\_\_\_

E. Level of activity (describe), including sleep habits or disturbances

Concentration ability \_\_\_\_\_

Ability to get along with others \_\_\_\_\_

F. List all major past illnesses, accidents, or operations: treatment given, age of incident and where treated and any changes in student because of condition.

**(Obtain parental or guardian's signature on release forms to obtain information from physicians, hospitals, etc. - Form 7)**

G. Vision or Hearing Problems (describe)

Student's Physician Name \_\_\_\_\_

<u>Vision</u>	<u>Date of Exam</u>	<u>Test Used</u>	<u>Test Findings</u>	<u>Examiner</u>
Acuity	_____	_____	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> CNT	_____
Muscle Balance	_____	_____	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> CNT	_____
<b>Hearing</b>	_____	_____	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> CNT	_____

Recommendations and comments

List health problems at present, describe medication or treatment prescribed

List problems you see in your child

Student Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

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H. Medical, Psychological, Speech Evaluations completed, e.g., EEG. (List names, addresses, dates of all special evaluations.)

**(Obtain parent or guardian signature on Authorization Form 7 to request information.)**

**Summary of findings**

Medical History

Current Health Status

Information secured by \_\_\_\_\_ Date of Interview \_\_\_\_\_

Informant \_\_\_\_\_ Relationship to student \_\_\_\_\_