POMONA UNIFIED SCHOOL DISTRICT

HEALTH & DEVELOPMENTAL HISTORY

(For use by School Nurse during Special Education Assessment)

Initial _____

3rd Yr._______

Update______

Date:__________

Student's Name____ ____________ _______ _____ __________

Last First Middle DOB Age Sex Gr.

School________________________ Student's Language__________________ Primary Home Language_______

Resides with____ ___________________________________

Name Relationship (Father, Mother, Guardian, etc.)

Address____Telephone___________________

Best Time to Call _____________

	Full Name	Age	Education	Occupation	In Home	Health Status
Mother						
Father						
Step-Parent						
Guardian						

Other Children (in order of age):

Name	Age	Relationship	School	Grade	School Difficulties	Health Status

Others in Home:

Describe your concerns about your child: ____

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SECTION 11

HOME AND ENVIRONMENTAL FACTORS

How long at present address? ____________

How many schools has child attended? __________ Does child like school? _______________

Did child attend Preschool or Head Start? Yes No

How does your child get along with family members?

____

____

Age group of friends? ____________________ Relationship w/peers? ________________________

Child care provider? Yes No No. hours: ____________________

What agency is working with your family? CCS Regional Center DCS Other

Mental Health Tri City Pacific Clinics

Can your child: dress, eat, bathe, toilet independently? Yes No

Which of the above areas does child need assistance with? ___________________________________

Do you have any concerns in the following areas:

EATING HABITS
Comments: _______________________________
____

SLEEP PATTERN
Comments: _______________________________
____

FALLS OFTEN? Yes No ACCIDENT PRONE? Yes No

BEHAVIOR (Check those that apply)

- Lies
- Steals
- Truant
- Dependable
- Destructive
- Friendly
- Sensitive to criticism
- Bossy
- Temper Tantrums
- Short attention span
- Often needs reminders
- Doesn't listen

SIGNS OF ANXIETY (Check those that apply)

- Stomach aches
- Frequent headaches
- Irritable
- Cries Easily
- Withdrawn
- Pulls Hair
- Bites nails
- Squints
- Nervous tics
- Sucks thumb

Comments:____

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BIRTH AND DEVELOPMENTAL FACTORS

PERINATAL FACTOR:

Mother's age_______When Prenatal Care Started_________ Length of Pregnancy___________

Length of labor________Birth weight______Child spent how many days in hospital__________

Were any of the following prenatal risks or complications present:

Illness	Smoking	Drugs
Accident	Alcohol	Other:_______________

Any complications at birth?

C-Section	Medications	Other:________________
Forceps used	Resuscitation	

Any complications after birth?

Incubation	Jaundice	Infection
Oxygen	Seizures	Blood transfusions
Other:_________________________________		

DEVELOPMENTAL MILESTONES – were you concerned about when your child started doing any of the following:

- Sitting alone
- Crawling
- Walking
- Talking
- Feeding self
- Toilet trained
- Dressing
- Other:________________________

Describe your concerns ____

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How does child's development compare to other children the same age? ___________________

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MEDICAL HISTORY

MEDICAL HISTORY: (check all that apply)

Head Injury	Asthma	Neuromuscular (CP)
Seizures	Pneumonia	Diabetes
Unconscious	Heart murmur	Chicken Pox
Headaches	Anemia	Tuberculosis
Eye problems	Sickle Cell test/results	Scarlet fever
Glasses, how old________	Stomach problems	Rheumatic fever
Hearing loss	Bone problems	Hepatitis
Ear infections/ache	Menarche – age/onset:___	Meningitis
Frequent sore throats/colds	Menstrual cramps	Temp. above 105º
Allergies	Bone/joint problems	ADHD
Hospitalizations/Surgeries	Special tests/treatment: (EEG, EKG, transfusions)	
Accidents	Special equipment (wheelchair, etc.)	
Chronic illness/Health concerns		

Explain all items checked above: ____

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Date of last physical exam: __________________ Date of last dental exam: __________________

Does your child take medications? Yes No Name of medication __________________

Frequency of medication: ______________________ Dosage: ____________________________

Health Insurance coverage: Yes No Name of Insurance_________________________

Medi-Cal Insurance: Yes No

Dental Insurance: Yes No

Physician _______________ Address _____________________________ Phone ________________

Specialist _______________ Address _____________________________ Phone ________________

Specialist _______________ Address _____________________________ Phone ________________

Dentist _________________ Address _____________________________ Phone ________________

FAMILY HISTORY: (medical problems, learning problems, special education classes) ______

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