****

Return to School Nurse ASAP or within two weeks of receiving. Thank you

*Education that inspires…Opportunities for all*

**GURNEE SCHOOL DISTRICT 56**

*3706 Florida Avenue • Gurnee, IL 60031 • 847-336-0800 • www.d56.org*

**Medical Review**

Please complete the following information regarding your child. Your answers will provide us with baseline information and the necessary data for problem identification and a working knowledge of your child as a unique individual. Thank you for your cooperation. Today’s Date:

**PLEASE RETURN THIS FORM TO YOUR CHILD’S SCHOOL OFFICE WITHIN ONE WEEK.**

**CHILD’S NAME:** **BIRTHDATE:** **AGE:**

**GRADE:** **TEACHER:**

**Name of Adult completing this form:**

Relationship to above named child:

[ ]  Birth Parent [ ]  Foster Parent [ ]  Adoptive Parent [ ]  Guardian

*To the best of your ability, please answer all of the questions, even if you feel they do not apply. Please ask the person who gave you this form for help if there is something you do not understand.*

**What are your main concerns?**

What is the best phone number to reach you?

What is the best time of day to reach you?

Do you prefer to be reached by email? [ ] No [ ] Yes, email address

**Parental Information**

Mother/Guardian’s Name       Age

Occupation      Employer      Military [ ] No [ ] Yes

Highest grade level completed?

Father/Guardian’s Name       Age

Occupation      Employer      Military [ ] No [ ] Yes

Highest grade level completed?

Does this child have other parents/stepparent(s)? [ ] No [ ] Yes, if yes please provide the following information.

Name       Relationship to this child

Name       Relationship to this child

**Primary Caregivers**

With what adult(s) does this child live?      How long in this current living situation

Who cares for this child when caregivers are gone?

How many hours per day is this child in a child-care setting?

**Pregnancy History** *Prenatal History is unknown* [ ]

Mother’s age during this pregnancy       Mother’s occupation during this pregnancy

Mother’s overall health during pregnancy: [ ] Excellent [ ] Good [ ] Fair [ ] Poor, explain

Father’s age during this pregnancy       Father’s occupation during this pregnancy

|  |  |  |
| --- | --- | --- |
|  YES | NO | **Pregnancy questions regarding student’s birth mother** | **Notes** |
|  [ ]  [ ]  | Was this a planned pregnancy? |       |
|  [ ]  [ ]  | Was there prenatal care? |       |
|  [ ]  [ ]  | Were prenatal vitamins taken? |       |
|  [ ]  [ ]  | Was her diet healthy during pregnancy? |       |
|  [ ]  [ ]  | Were alcohol or take illegal drugs taken during pregnancy? | What kind:       |
|  [ ]  [ ]  | Were cigarettes smoked during pregnancy? |       |
|  [ ]  [ ]  | Were prescription medications taken during pregnancy? | What kind:      |
|  [ ]  [ ]  | Were over the counter medications taken during the pregnancy? | What kind:      |
|  [ ]  [ ]  | Was caffeine taken (coffee/soda/tea)? |       |
|  [ ]  [ ]  | **Medical Diagnoses during pregnancy** |  |
|  [ ]  [ ]  | High Blood Pressure/Preeclampsia |  |
|  [ ]  [ ]  | Gestational Diabetes |  |
|  [ ]  [ ]  | Weight gain during pregnancy: [ ]  0-20# [ ] 21-30# [ ] 31-more# |  |
|  [ ]  [ ]  | Injury or serious illness |  |
|  [ ]  [ ]   | Bleeding/spotting (when/how long) |  |
|  [ ]  [ ]  | Emotional Stress |  |
|  [ ]  [ ]  | Abnormal lab work (low hemoglobin, low Vitamin D, others) |  |

**Birth History** *Birth History is unknown* [ ]

Due Date       Gestational Age at time of birth      (weeks) Birth Weight

Was the baby[ ] early [ ] late [ ] on time Was your baby considered premature? **[ ]** Yes, how many weeks early

[ ] Vaginal Birth [ ] C-section [ ] Forceps or Vacuum [ ] Medications for pain

[ ] Hospital Birth [ ] Home Birth [ ] Other **Passed Newborn Hearing Screening:**  **[ ]** No **[ ]** Yes

How long did baby stay in hospital?     How long did mother stay in hospital ?

Was mother sick with infection or fever during the delivery or shortly after? [ ]  No [ ] Yes, explain

If the baby stayed longer then the mother, why?

APGAR scores       (if known)

**Did the baby have any of the following problems or needs?**

|  |  |
| --- | --- |
| YES | **Birth Issues** |
| [ ]  | Oxygen needed? How long?       |
| [ ]  | Intubation |
| [ ]  | Heart issues |
| [ ]  | Jaundice |
| [ ]  | Treated with bilirubin (phototherapy) lights? How long?       |
| [ ]  | Any medications used? List:       |
| [ ]  | Any emergency surgeries or procedures at birth or shortly after? List:       |
| [ ]  | Any scans (MRI, CT, X-ray) or labs required at birth? List:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Any other concerns or comments regarding your child’s birth

**First Year of Life** *History is unknown* [ ]

 Would you say your child’s health in the first year of life was [ ] Excellent [ ] Very Good [ ] Good

[ ] Fair [ ] Poor, explain

**Health Problems in the first year of life**

|  |  |  |
| --- | --- | --- |
| YES | NO | Feeding problems (poor sucking, vomiting, choking…) explain, |
| [ ]  | [ ]  | Sleeping problems |
| [ ]  | [ ]  | Infections (high fever…) |
| [ ]  | [ ]  | Seizures (with or without fever) |
| [ ]  | [ ]  | Birth defects |
| [ ]  | [ ]  | Special tests or medications needed. Explain, |
| [ ]  | [ ]  | Special equipment or treatments needed at home, explain |
| [ ]  | [ ]  | Was Physical Therapy or any other type of therapy needed? Explain       |

Any other issues or concerns in the first year of life?

**Developmental Milestones,** please check yes if your child met these milestones in the specified time frame

*History is unknown* [ ]

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** | **NO** | **Milestones accomplished**  | **If NO, age accomplished** |
| **[ ]**  | **[ ]**  | Rolled over by age 7 months |  |
| **[ ]**  | **[ ]**  | Responded to noises/smiles by age 7 months |  |
| **[ ]**  | **[ ]**  | Made babbling sounds by age 7 months |  |
| **[ ]**  | **[ ]**  | Crawled by age 12 months |  |
| **[ ]**  | **[ ]**  | Stood without support by age 12 months |  |
| **[ ]**  | **[ ]**  | Spoke a single word by age 12 months |  |
| **[ ]**  | **[ ]**  | Used gestures such as waving bye-bye by 12 months |  |
| **[ ]**  | **[ ]**  | Walked without help by age 18 months |  |
| **[ ]**  | **[ ]**  | Spoke at least 6 words by age 18 months |  |
| **[ ]**  | **[ ]**  | Used a cup by age 24 months |  |
| **[ ]**  | **[ ]**  | Scribbles by age 24 months |  |
| **[ ]**  | **[ ]**  | Followed simple instructions by age 24 months |  |
| **[ ]**  | **[ ]**  | Spoke simple sentences by age 24 months |  |
| **[ ]**  | **[ ]**  | Plays with other children by age 36 months |  |
| **[ ]**  | **[ ]**  | Socialized with non-family members by age 36 months |  |
| **[ ]**  | **[ ]**  | Made eye contact by age 36 months |  |
| **[ ]**  | **[ ]**  | Able to throw and kick a ball by age 36 months |  |
| **[ ]**  | **[ ]**  | Speech easily understood by strangers by age 36 months |  |
| **[ ]**  | **[ ]**  | Able to name familiar objects such as shoes by age 36 months |  |

**Were any of your child’s skills/developmental milestones lost after 24 months of age?** [ ] No [ ]  Yes, explain

|  |  |
| --- | --- |
| **Early Childhood Development** | Age |
| Ride a bicycle |       |
| Catch a ball |       |
| Tie shoe laces |       |
| Use a scissors |       |
| Write name |       |
| Toilet trained daytime |       |
| Toilet trained night time |       |

**Illness History Check** all of those that apply, please give a brief description and include student’s age at time of condition.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Yes** | **Illness/Condition** | **Description** | **Age** | **Yes** | **Illness/Condition** | **Description** | **Age** |
| [ ]  | Strep Throat (multiple episodes) |       |       | [ ]  | **Genetic Condition** |       |       |
|  [ ]  | Chicken Pox |       |       | [ ]  | Thyroid Diagnosis |       |       |
| [ ]  | Measles/German Measles/Mumps |       |       | [ ]  | **Rheumatoid Arthritis** |       |       |
| [ ]  | Skin Condition |       |       | [ ]  | Joint or Muscle Problems |       |       |
| [ ]  | Eczema |       |       | [ ]  | Growth or Developmental Delay |       |       |
| [ ]  | **Asthma** |       |       | [ ]  | Short Stature |       |       |
| [ ]  | Rescue Inhaler for Asthma |       |       | [ ]  | Taking Growth Hormones |       |       |
| [ ]  | Bronchitis/Reactive Airway Disease |       |       | [ ]  | Failure to Thrive |       |       |
| [ ]  | Allergies |       |       | [ ]  | **Blood Disorder** |       |       |
| [ ]  | **Life-Threatening Allergies** |       |       | [ ]  | **Cancer** |       |       |
| [ ]  | Epi Pen for treating life threatening allergies |       |       | [ ]  | History of Chemotherapy or Radiation |       |       |
| [ ]  | Fever above 104 |       |       | [ ]  | **Kidney or Urinary Problems** |       |       |
| [ ]  | **Seizures/Convulsion/Tics/Twitches** |       |       | [ ]  | Frequent Ear Infections |       |       |
| [ ]  | **Neurologic Condition** |       |       | [ ]  | Ear Tubes/Ear Surgery |       |       |
| [ ]  | Headache/Migraines |       |       | [ ]  | **Hearing Problems** |       |       |
| [ ]  | Head Trauma/Concussion |       |       | [ ]  | Cochlear Implant |       |       |
| [ ]  | **Cardiac/Heart Condition** |       |       | [ ]  | Hearing Aid/Sound Device |       |       |
| [ ]  | Heart Murmur |       |       | [ ]  | **Eye Problems** |       |       |
| [ ]  | **Stomach/Intestinal Problems** |       |       | [ ]  | Glasses or Contact Lenses |       |       |
| [ ]  | Frequent Stomach Aches |       |       | [ ]  | **Orthopedic Problems** |       |       |
| [ ]  | Crohn’s/IBD/Diverticulitis |       |       | [ ]  | Broken bone/Fracture |       |       |
| [ ]  | Constipation |       |       | [ ]  | Scoliosis |       |       |
| [ ]  | Chronic Diarrhea |       |       | [ ]  | Orthotic Devices/Splints |       |       |
| [ ]  | Wetting or soiling problems |       |       | [ ]  | Activity Limitations or Restrictions  |       |       |
| [ ]  | Celiac Disease |       |       | [ ]  | Accidents/Falls/Injury |       |       |
| [ ]  | Lactose Intolerance |       |       | [ ]  | **Mental Health Diagnosis** |       |       |
| [ ]  | **Diabetes I or II** |       |       | [ ]  | Anxiety |       |       |
| [ ]  | Tuberculosis or exposure to |       |       | [ ]  | Depression |       |       |
| [ ]  | Positive tuberculin test |       |       | [ ]  | ADHD or Focus concerns |       |       |
|  |  |  |  | [ ]  | Oppositional Defiant Behaviors |       |       |
| [ ]  | Unusual Fears |       |       | [ ]  | Obsessive Compulsive symptoms |       |       |
| [ ]  | Physical Abuse |       |       | [ ]  | Autism/ PDD/Asperger’s |       |       |
| [ ]  | Sexual Abuse |       |       | [ ]  | Hospitalization (add reason and dates) |       |       |
| [ ]  | Neglect |       |       | [ ]  | Surgery (add type and dates) |       |       |

Please give details here:

Please make note of any other medical issues or concerns:

**Medical Diagnoses:**

**Date diagnosed:**

**Physician’s name:**

**Physician History** (doctors your child has seen)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Type of Physician | Physician’s Name/Reason for visit/Frequency of visits | Age at time of visit(s) |
|  | Pediatrician |       |       |
|  | Allergist |       |       |
|  | Cardiologist |       |       |
|  | Ear/Nose/Throat Specialist |       |       |
|  | Endocrinologist |       |       |
|  | Gastroenterologist |       |       |
|  | Neurologist |       |       |
|  | Ophthalmologist/Optometrist (Eye Doctor) |       |       |
|  | Orthopedic (Bone Doctor) |       |       |
|  | Psychiatrist/Psychologist |       |       |

**Has your child received any therapy**: [ ] Physical [ ] Occupational [ ] Speech At what age?

Your child is: [ ]  Right-Handed [ ]  Left-Handed [ ]  Both

**Student Lifestyle**

Do you think your child’s health is: [ ] Excellent/Very healthy [ ] Usually healthy/Occasionally ill [ ] Sick more frequently than other children [ ]  Sick “all the time”

How does your child perceive his/her health, is it similar to your perception?

Does your child’s teacher ever express concerns to you regarding your child’s health, illnesses, or absenteeism? If so, please explain:

|  |
| --- |
| Sleeps from pm until am  |
| Sleeps through the night | [ ]  Yes | [ ]  No |
| How long does it take your child to fall asleep?  |  |  |
| How much screen time (TV and electronics) is your child allowed each day?  |  |  |
| Does the student have access to electronics in his/her bedroom throughout the night?  | [ ]  Yes | [ ]  No |
| What limitations are in place? |  |  |

**Medications,** please list name, dosage and time taken

**List Vitamins and/or herbal supplements:**

**Nutrition**

Does your child eat a well-balanced diet? [ ]  No [ ] Yes, if no explain

Is your child a picky eater? [ ]  Yes [ ]  No

Is your child a vegetarian or vegan? [ ]  Yes [ ] No

Does your child have any dietary restrictions? [ ]  Yes [ ]  No, explain

Does your child drink caffeine? ☐ Yes, how much and how often

**Environment**

Is your child exposed to cigarette smoke? [ ]  Yes [ ]  No

Is there a gun in your home? [ ]  Yes. [ ]  No.

If yes, is it locked away and inaccessible to your child? [ ]  Yes [ ]  No

Are there pets in the home? [ ]  Yes [ ] No list pets, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities of Daily Living**

Briefly describe a typical day for your child:

Is your child able to perform all activities of daily living? (Dress themselves, zippers, brush teeth…)

 [ ]  Yes [ ]  No, if no please explain

Please make note of any concerns not mentioned above:

**Family Information**

Has this child ever experienced parental separations, divorces, or death of a family member? [ ]  No [ ]  Yes

 If yes, when?      What was the child’s age at the time?

 Please describe the circumstance and the affect it had on your child:

**Siblings:** Please list all siblings, and any other children

LIVING IN THE HOME WITH FAMILY. NOT LIVING IN THE HOME WITH FAMILY.

|  |  |  |  |
| --- | --- | --- | --- |
| AGE | Name of brother or sister | AGE | Name of brother or sister |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Has anyone in the family had any of the following?** If yes please specify relationship to child in space provided.

(Biological family health history unknown [ ] )

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YES|NO | Disease/Illness/Condition | Relation to student | YES|NO | Disease/Illness/Condition | Relation to student |
| [ ]  [ ]  | ADD/ADHD |       | [ ]  [ ]  | LEARNING DISABILITY |       |
| [ ]  [ ]  | AUTISM/PDD/ASPERGER |       | [ ]  [ ]  | MENTAL ILLNESS/ANXIETY/DEPRESSION |       |
| [ ]  [ ]   | ALCOHOL/DRUG ABUSE |       | [ ]  [ ]  | NEUROLOGICAL CONDITION |       |
| [ ]  [ ]  | BEHAVIOR DISORDER |       | [ ]  [ ]  | OTHER GENETIC CONDITION |       |
| [ ]  [ ]  | CANCER |       | [ ]  [ ]  | SEIZURES/EPILEPSY/TWITCHING/TICS |       |
| [ ]  [ ]  | DIABETES |       | [ ]  [ ]  | SPECIAL EDUCATION |       |
| [ ]  [ ]  | HEART DISEASE |       | [ ]  [ ]  | SPEECH OR LANGUAGE PROBLEM |       |

IF YES, PLEASE EXPLAIN HERE

**Please note anything else you would like to share about your child’s health history here**:

Thank you for your time.

