PLEASE RETURN TO SCHOOL NURSE

Case Manager ___________
Date of IEP _____________
Initial___ Annual___ Tri___

VISTA UNIFIED SCHOOL DISTRICT
School Nursing Assessment Questionnaire
CONFIDENTIAL

Student's Name ______________ _______________________ (Last Name, First Name) Sex ☐ Male ☐ Female Birthdate ___________ Age _____

Address ____ School _____________ Grade ____

Mother's Name __________________________ Home Phone ___________________ Work Phone ___________________

Father's Name ______________ ____________ Home Phone ___________________ Work Phone____________________

FAMILY HISTORY

1. Language spoken in home? ____________________________
2. Please list all individuals living in the home.

Name	Age	Relationship	Name	Age	Relationship

3. Have there been any major changes in the student's home life or living situation? ☐ Yes ☐ No
   If yes, circle all that apply: separation, divorce, marriage, new baby, death. Number of moves: ______
4. Has the student lived with you continuously since birth? ☐ Yes ☐ No
   If no, how long was child out of the home? ____
5. Do any family members have learning, health or mental health problems? ☐ Yes ☐ No
   If yes, describe: ____

PREGNANCY

1. Age of mother during this pregnancy? _________________
2. Did mother receive prenatal care? ☐ Yes ☐ No **If yes, starting at what month?** _________________
3. Were there any illnesses or accidents during pregnancy? ☐ Yes ☐ No
   If yes, please explain: ____
4. Did mother take any prescription or over-the-counter medicine during the pregnancy? ☐ Yes ☐ No
   If yes, please explain: ____
5. Did mother take any street or other drugs during the pregnancy? ☐ Yes ☐ No
   If yes, please explain: ____
6. Did mother drink alcohol during the pregnancy? ☐ Yes ☐ No **If yes, how much:** _____________________________
7. Did mother smoke tobacco during the pregnancy? ☐ Yes ☐ No **If yes, how much:** ____________________________

BIRTH

1. Was baby born in a hospital? ☐ Yes ☐ No **If yes, where?** ____
2. Was baby born early (prematurely)? ☐ Yes ☐ No **If yes, how many weeks early?** _________________
3. Type of delivery: ☐ Vaginal (normal) ☐ Caesarean section
   If caesarean, reason why? ____
4. Were there problems during delivery? ☐ Yes ☐ No
   If yes, please explain: ____
5. Did baby have problems starting to breathe? ☐ Yes ☐ No
   If yes, please explain: ____
6. Was baby born with any birth defects? ☐ Yes ☐ No **If yes, please explain:** ___________________________________
7. Did baby go home with the mother? ☐ Yes ☐ No **If no, please explain:** ____________________________________
8. Birth weight: _________________
9. Did the baby gain weight normally? ☐ Yes ☐ No
10. Please check all that applied to your baby: ☐Quiet ☐Colicky ☐Cuddly ☐Sickly ☐Happy ☐Easy Going ☐Fussy

☐Active ☐Other: ____________________

GROWTH AND DEVELOPMENT

1. As best as you can remember, when did your baby learn the following tasks? **WRITE IN AGE**
   _____ Sat without support _____ Walked alone _____ Talked in 2-3 word sentences
   _____ Crawled _____ Spoke single words _____ Toilet trained
2. Does your child wet the bed now? ☐ Yes ☐ No Soil or wet his/her pants now? ☐ Yes ☐ No
3. Were you ever worried about your baby being slow to develop? ☐ Yes ☐ No
   If yes, please explain: ____________________
4. Has your child ever received speech therapy? ☐ Yes ☐ No **If yes, when/where?** ____________________

HEALTH AND ACCIDENT HISTORY

1. Please check all of the following illnesses, accidents, or conditions that your child has or has ever had:

☐ ADD/ADHD	☐ Cancer	☐ Headaches	☐ Respiratory problems
☐ Anemia	☐ Cerebral Palsy	☐ Heart problems	☐ Seizures
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Sustained fever over 104
☐ Autism	☐ Eczema	☐ Kidney problems	☐ Tremors
☐ Broken bones	☐ Frequent cough	☐ Meningitis	☐ Twitches
☐ Burns	☐ Frequent colds	☐ Overweight	☐ Other:

Explain and list age of occurrence of problems checked above: ____________________

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2. Please check any of the following allergic reactions your child has or has ever had:

Serious Allergic Reaction to:	**What plan of action is taken:**
☐Insect Stings- What kind? ____________ ☐Food- What kind? ____________ ☐Environmental- What triggers? ____________ ☐Medicine- What kind? ____________ ☐Other ____________	☐Benadryl ☐Epi-Pen ☐Call 911 ☐Special Diet:____________ Please Note: medical authorization is needed for medication and special diet for school meals. **Please see school nurse.**

3. Has your child had any chronic illness, operations, serious accidents, or hospitalizations? ☐ Yes ☐ No
   If yes, please explain: ____________________
4. Please list any current medications your child is taking, including vitamins or over-the-counter medications:
   Medication: __________ Condition: __________ Time: _____ Dose: __________
   Medication: __________ Condition: __________ Time: _____ Dose: __________
   Medication: __________ Condition: __________ Time: _____ Dose: __________
5. Does your child have eye problems? ☐ Yes ☐ No **If yes, circle all that apply**: lazy eye, crossed eyes, allergies
6. Does your child wear glasses? ☐ Yes ☐ No **If yes, circle all that apply:** reading, distance
7. Has your child ever had ear or hearing problems? ☐ Yes ☐ No
   If yes, circle all that apply: infections, earaches, drainage, tubes, hearing loss At what age? __________
8. Does your child wear hearing aids? ☐ Yes ☐ No Indicate which: Rt. ☐ Lt. ☐ Both ☐
9. Date of last dental exam: __________ Name of dentist: ____________________
10. Date of last physical exam: __________ Name of physician: ____________________
11. Does your child see any medical or behavioral specialists? ☐ Yes ☐ No
    If yes, name and specialty: ____________________
12. Is there anything else you think the school should know about your child?
    Please explain: ____________________

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Name of person completing from: ____________________ Relationship to student: ____________

Date: ____________

Revised: 01/25/2017