CENTRAL UNION SCHOOL DISTRICT
Special Education
Developmental—Medical—School History

To the parent: Please note that the developmental history is a required component of the Special Education Assessment process. Please answer the questions in this questionnaire to the best of your ability. **All answers/responses are kept confidential.** The information that is provided will assist the Individualized Educational Plan team during the assessment of your child's educational needs. If you have any questions pertaining to this developmental history please contact the school nurse through the school office. Thank you.

Family Data:

Child's Name: ____ Date of Birth: _____________________ Age: _________________

Home Address: ____ Phone: ________________________________

Primary Language Spoken in the Home: ____

Father's Name: ____ Age: _____________ Employment: __________________________

Living in home: Yes ____ No ____ Highest Level School Completed: ____

Mother's Name: ____ Age: _____________ Employment: __________________________

Living in home: Yes ____ No ____ Highest Level School Completed: ____

Family Medical History:	Y	N	Relation	Family Mental Health History:	Y	N	Relation
Allergies	___	___	________________	ADD/ADHD	___	___	_________________
Asthma	___	___	________________	Anxiety Disorder	___	___	_________________
Blood Disorder	___	___	________________	Drug/Alcohol Abuse	___	___	_________________
Cancer	___	___	________________	Autism	___	___	_________________
Diabetes	___	___	________________	Bipolar	___	___	_________________
Heart Disease	___	___	________________	Learning Problems	___	___	_________________
Seizure Disorder	___	___	________________	Mental Retardation	___	___	_________________
Other: _________________	___	___	________________	Other: _____________________	___	___	_________________

Pregnancy History:

What number of Pregnancy for mother: ________ Mother's age at Pregnancy: _________ Mother receive prenatal care: Y N

Please circle any of the illnesses/complications during pregnancy: Measles, German measles, Chicken Pox, Toxemia, Diabetes, Serious bleeding, injury, emotional problems, other: ____

List medications mother took during pregnancy: ____

Did mother smoke cigarettes during pregnancy? Y N circle light moderate heavy

Did mother drink alcohol during pregnancy? Y N circle light moderate heavy

Did mother use illicit drugs during pregnancy? Y N What?____

Birth History:

How long was labor:__________________________ Vaginal or C-Section birth?____

If C-Section Why?____(Emergency—Scheduled)

Birth weight: _____ pounds _____ ounces _______ Circle: Premature ____Weeks On time Late ______Weeks

Did the baby have any problems at birth? Y N If yes explain:____

Did the baby need oxygen after birth? Y N If yes for how long:____

Did the baby go home with mom? Y N If no why not?____

Student's Medical History

General Medical Information:

Medication Allergies? ______________________________________ Medical Insurance: ____

Primary Physician? ____ Specialists? ____

Eye Doctor? ____ Dentist? ____

Other Agencies? (Social Services, CPS, CVRC, UCP etc.)____

Developmental Milestones:

Age at which child: Sat_______ Crawled _______ Walked_____ Spoke Single Words_______ Spoke Sentences_______

Toilet Trained: Bladder_____ Bowel______ Night-time_______

Development was: Earlier Same Later than siblings?

Current Medications:

Over the Counter Medications? Y N if yes what?____

Prescription Medications? Y N if yes what?____

Herbal Remedies? Y N if yes what?____

Glasses/Contacts? Y N if yes for what?____

Hearing Apparatus? Y N if yes for what level of loss?____

Medical Device (crutches, walker, w/c, etc)? Y N if yes what & why?____

Has the child ever been diagnosed with: (Age Diagnosed) **Explain**

Condition	Y/N	Age	Resolved	Ongoing	Explain
1. ADHD	Y N	Age: ______	Resolved	Ongoing	______________________
2. Allergies	Y N	Age: ______	Resolved	Ongoing	______________________
3. Asthma	Y N	Age: ______	Resolved	Ongoing	______________________
4. Dental Prob	Y N	Age: ______	Resolved	Ongoing	______________________
5. Diabetes	Y N	Age: ______	Resolved	Ongoing	______________________
6. Eating Prob	Y N	Age: ______	Resolved	Ongoing	______________________
7. Ear Infect.	Y N	Age: ______	Resolved	Ongoing	______________________
8. Skin Cond	Y N	Age: ______	Resolved	Ongoing	______________________
9. Freq. Colds	Y N	Age: ______	Resolved	Ongoing	______________________
10. Headaches	Y N	Age: ______	Resolved	Ongoing	______________________
11. Heart Disorder	Y N	Age: ______	Resolved	Ongoing	______________________
12. Kidney Probs	Y N	Age: ______	Resolved	Ongoing	______________________
13. Nose Bleeds	Y N	Age: ______	Resolved	Ongoing	______________________
14. Seizures	Y N	Age: ______	Resolved	Ongoing	______________________
15. Sleep Problems	Y N	Age: ______	Resolved	Ongoing	______________________
16. Snoring	Y N	Age: ______	Resolved	Ongoing	______________________
17. Fractures	Y N	Age: ______	Resolved	Ongoing	______________________
18. Vision Probs	Y N	Age: ______	Resolved	Ongoing	______________________
19. Hearing Probs	Y N	Age: ______	Resolved	Ongoing	______________________
20. Other ________________	Y N	Age: ______	Resolved	Ongoing	______________________

Hospitalizations: Y N if Yes Why and When ____

Surgeries: Y N if Yes Why and When ____

Parent Signature ____Date___________________________ HF-3