Elko County School District
Health/Development Review for INITIAL Special Services Evaluation

Student Name:_____ Date:_____

Grade:_____ Date of Birth:_____ Age_____ Years/Months

Name of person completing form and relationship to student:_____

_____

Student living with: Both Parents ☐ Mother ☐ Father ☐ Foster ☐

Number of adults living in the household and their relationship to the child:_____

_____

How many brothers and/or sisters and what are the ages?_____

_____

Natural Parent(s) Names/Involvement if not in home:_____

_____

FAMILY HEALTH HISTORY:

Are there any significant health conditions of immediate family that may affect your child's learning, behavior or attendance?_____

_____

Did any family members have problems with learning? (i.e. required tutoring or special education, dropped out of school, repeated a grade, etc.)_____

_____

Have there been any stressful situations in the family (i.e. serious illness, death, marital separation, remarriage, financial problems, new sibling, etc.)_____

_____

PRENATAL AND BIRTH HISTORY:

Mother's health during pregnancy:_____

Received prenatal care?_____ Was pregnancy full term?_____

Any complications or health problems during pregnancy?_____

_____

_____

Medications during pregnancy:_____

Alcohol use?_____ Tobacco use?_____ Other Drug use?_____

Any Labor/Delivery Problems?:_____

☐ C-Section ☐ Vaginal Delivery Mother's age at delivery:_____

Baby's condition at Birth (APGAR SCORES if available)_____

Did baby need oxygen at birth?_____ Birth weight:_____

Length of hospital stay for Mother:_____ For Baby:_____ Additional comments:_____

_____

Any medical concerns during the first 12 months?_____

_____

DEVELOPMENTAL HISTORY *(indicate approximate age, if known)*

	Earlier than Expected	***When Expected***	***Later than Expected***
Sat Alone			
Crawled			
Walked Alone			
Said words other than Mama, Dada			
Put three words in a sentence			
Toilet trained			

Did your child attend preschool?_____

How many schools has he/she attended? Elementary_____ Middle_____ High School_____

Elko County School District

Health/Development Review for INITIAL Special Services Evaluation

STUDENT HEALTH HISTORY:

Student's Health Care Provider:_____

Date of last medical visit:_____ Reason for visit:_____

Results of exam:_____

Student's Dentist:_____ Date of last dental visit:_____

Does she/he have health insurance?_____ Dental insurance?_____

What health conditions has the student been diagnosed with or received medical treatment for?_____

_____

Any overnight hospitalizations?_____

Has he/she had any significant injuries requiring medical attention? (i.e poisonings, fractures, head injuries)_____

_____

Does your student have a history of frequent ear infections?_____

If yes, which ear and how often?_____Have tubes ever been placed/date?_____

Is student currently under medical care for any condition?_____

Medications taken at home:_____

Medications taken at school:_____

Does your child have any physical limitations or require adaptive equipment or facility adaptations?_____

If yes, what?_____

Describe appetite (Circle One) Good Fair Poor Comments:_____

Usual bedtime & rising:_____ Any sleep difficulties?_____

Is he/she able to physically keep up with other children?_____

Favorite activities/hobbies/interests:_____

Does he/she participate in any extracurricular or community groups? (i.e. playgroups, church groups, clubs)?_____

_____

Describe Relationships with Siblings_____Peers:_____Adults:_____

Does he/she make friends EASILY or SLOWLY? Number of friends: FEW/MANY/ONE GOOD

How would you describe his/her personality? (circle all that apply): SHY/OUTGOING/QUIET/ACTIVE/CONFIDENT/ TALKATIVE/WITHDRAWN/OTHER:_____

Any recent behavior changes/concerns?_____

Attitude toward school: _____

Subject/class likes:_____Dislikes:_____

Have there been any changes in the student's life or family issues that may be affecting the student's school performance?_____

_____

Additional comments/information:_____

_____

_____

_____