WILLIAMSBURG COUNTY SCHOOL DISTRICT

Office of Special Services

500 N. Academy St. Bldg. – A, Kingstree, SC 29556 (843) 355-5533

August 2014

CONFIDENTIAL HEALTH AND DEVELOPMENTAL HISTORY

SIT-5

This information will only be used by the school psychologist as a part of a comprehensive evaluation of your child. Your input is appreciated.

Child's Name ________________________________ Birth Date __________ Age ______ Sex ______
Grade/School ____________________ Address ________________________________
Phone # ____________________ Social Security # ____________________ Medicaid # ____________________
****

PARENT RELATIONSHIP
(circle one) Are parents married, divorced, separated? How long ? ____________

FAMILY HISTORY – MOTHER

Name: ________________________________ Current Age ______ Age at time of pregnancy with child: ______
School: Highest grade completed ________ Grade(s) repeated ____________ Occupation: ________________
Learning problems (Specify) ____
Behavior problems (Specify) ____
Medical problems (Specify) ____
Have any of your blood relatives (not including the child and siblings) ever had problems similar to those your child has? If so, describe: ____

FAMILY HISTORY – FATHER

Name: ____________________________ Current Age ______ Age at time of the child's conception: ________
School: Highest Grade completed: __________ Grade(s) repeated ____________ Occupation: ________________
Learning problems (Specify) ____
Behavior problems (Specify) ____
Medical problems (Specify) ____
Have any of your blood relatives (not including the child and siblings) ever had problems similar to those your child has? If so, describe: ____
****

Your Name ______________________ Relationship to the student ______________________
Child adopted? __________ Child in custody of ____________________________
Foster Care? __________ Caseworker __________________________ County ____________________
****

OTHER PERSON(S) IN THE HOME:

Name	Age	Relationship to Student

What language is most often spoken at home? ____________________________
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A. DEVELOPMENTAL HISTORY

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Reason for Referral: Please give a statement of your concerns and any expressed by teachers or others. List all concerns, with those of greatest importance described first.

____

____

____

I. PREGNANCY

Duration of pregnancy ____________

Were any of the following complications present during pregnancy (check those that apply)? If so, describe:

	Threatened miscarriage
	Infection (s) or illness (Specify)
	Toxemia /Swelling
	Smoking during pregnancy (Average cigarettes per day?)
	Alcohol consumption during pregnancy (Describe, if beyond an occasional drink)
	Drugs during pregnancy (Specific drug and indicate how often)
	Medications taken during pregnancy
	Other complications

II. DELIVERY (check those that apply)

	Birth Weight ______ lbs. ______ oz.		**Complications:**
	Type or Delivery:		Cord around neck
	Vertex (normal)		Cord presented first
	Breech		Hemorrhage
	Cesarean		Infant injured during delivery
			Other (Specify) ____________

III. POST DELIVERY PERIOD (While in the hospital)

Did your child have any of the following immediately after birth (check those that apply)?

	Fever		Bleeding
	Feeding problems		Seizures/Convulsions
	Allergies		Breathing problems
	Brain Injury		Cyanosis (Turned Blue)
	High Blood Pressure		Incubator Care (Number of Days ________)
	Excessive Vomiting		Birth Defects (Specify)

Total number of days baby was in the hospital after the delivery: ____________

Describe other problems not listed ______________________________

IV. DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, write early, normal, or late. EARLY = E, NORMAL =N, LATE =L

	E/N/L		E/N/L
Sat without support		Bladder trained, day,	
Crawl		Bladder trained, night	
Stood without support		Buttoned clothes	
Walked without assistance		Tied shoelaces	
Said phrases		Named colors	
Bowel trained, day		Said alphabet in order	
Bowel trained, night		Began to read	

V. MEDICAL HISTORY

Is your child in good health? ____ Yes____ No

Date of last physical: ____________

If your child's history includes any of the following please indicate. Please indicate the age and comment on the height and duration of temperature, complications, and any unusual results.

	SLEEP PROBLEMS		CHRONIC COLDS
	EYE PROBLEMS		ALLERGIES
	FREQUENT EAR INFECTIONS		ASTHMA
	DIABETES		TONSILLECTOMY
	MEASLES		ADENOIDECTOMY

II. MEDICAL INFORMATION

Did the mother have any of these complications during this pregnancy?

	YES	NO	
Anemia			Describe:
Took Medication			Describe:
Bleeding			Describe:
Heart Disease			Describe:
Kidney Disease			Describe:
Diabetes			Describe:
High Blood Pressure			Describe:
German Measles			Describe:
Smoking			If YES, how much?
Alcohol Intake			If YES, how much?

Was the baby premature? ____Yes ____No If YES, number of months?______________________
How much did the baby weigh? ________pounds ________ ounces
Type of delivery? _____ Vertex (normal) ____ Cesarean

Indicate if your child has received or currently receives any treatment for any of the following.

Medical Illnesses	YES	NO	Age when illness occurred	Length of illness	After effects of illness
Anemia					
Allergies					
Head Injury					
Accident					
Asthma					
Hearing Problems					
Diabetes					
Excessive Vomiting					
Feeding Problems					
Visions Problems					
ADHD					
Frequent Ear Infections					
Seizures					
High Fever					
Tubes in ears					
Other:					

Has the student ever been admitted to the hospital *other* than at birth? ____ Yes ____ No
If Yes, Explain____

Does the student have frequent illnesses? ____Yes ____No
If Yes, explain____

Does the student have allergies/food allergies? ____Yes ____No
If Yes, explain____

Does the student regularly take medication? ____Yes ____No What Medication? ____________________
How often?______________ How much?__________________

Does the student wear glasses or a hearing aid? ____Yes ____No (specify______________________________)

Has your child ever been diagnosed with a Medical condition/syndrome? ____Yes ____No
If Yes, explain____

	SCARLET FEVER		BLACKOUTS
	RHEUMATIC FEVER		GLANDULAR DISTURBANCES
	MUMPS		EXTREME FATIGUE
	PNEUMONIA		SERIOUS HEAD INJURIES
	HIGH BLOOD PRESSURE		CONVULSIONS/SEIZURES
	HEADACHES		SICKLE CELL
			OTHER

Describe any surgery the child has had:____________________
Describe any other serious illnesses, accident, falls, or deformities not already mentioned:
____

Medication prescribed for child:

MEDICATION	*DOSAGE*

List other types of diagnoses or special services the child has received:____________________

VI. **ACADEMIC**

Rate your child's school experience related to academic learning as Good, Average, or Poor:
Pre-K/Kindergarten ____________ Elementary ____________ Current Year ____________
Did your child have trouble learning with Reading ________ Spelling ________ Arithmetic ________?
Has your child ever had to repeat a grade? If so, which grade? ________________

Please list schools your child has attended outside of Williamsburg County School District:

SCHOOL	**CITY**	**STATE**	**GRADES ATTENDED**

B. **SOCIAL HISTORY**

I. **CONDUCT**

Rate your child's school experience related to behavior as Good, Average, or Poor:
Pre-K/Kindergarten ____________ Elementary ____________ Current Year ____________

Has you child demonstrated: (check those that apply)

	Lying		Juvenile court involvement
	Stealing		Mental Heath
	Discipline problems: (school)		Department of Social Services
	Discipline problems: (home)		Others: ____________

*If yes to any of the above please explain:
____

Does this child get along with teachers? Y or N
Has he/she ever been suspended? Y or N Reason: ____________________
Does this child have any unusual habits, fears, or behavior(s)? Y or N If Yes, please list:
____
Describe how this child feels about themselves in relation to school/learning:____________________
Does your child's teacher describe any of the following as significant classroom problems? (check those that apply)

	Doesn't sit still in his or her seat		Typically does better in one-on-one relationships
	Frequently gets up and walks around the classroom		Doesn't respect the rights of others
	Shouts out. Doesn't wait to be called upon		Doesn't pay attention
	Won't wait his or her turn		Gives up easily
	Does not cooperate well in group activities		

Describe briefly any other classroom behavioral problems: ____________________

II. **RELATIONSHIPS WITH OTHER CHILDREN**

How well does your child get along with siblings (brother/sisters)? (CIRCLE ONE) Excellent or Good or Poor

Does your child seek friendships with other children? Y or N
Is your child sought by other children for relationships? Y or N
Does your child play primarily with children ________his or her own age? _____Younger? ______ Older?
Does your child participate in group activities? Y or N
Sports/Clubs ____
What does he/she do for fun? ____

III. HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Please rate your child's behavior when he/she is compared to other children his/her own age. AVERAGE = AVG, EXCESSIVE = EXC

	AVG	EXC		AVG	EXC
Hyperactivity (High activity level)			Acts as though driven by a motor		
Poor attention span			Heedless to danger		
Impulsivity (Poor self-control)			Excessive number of accidents		
Low frustration threshold			Doesn't learn from experience		
Temper outburst			Poor memory		
Careless table manners			More active than siblings		
Interrupts frequently			Tends to worry		
Doesn't listen when being spoken to			Feels depressed		

Please describe any significant changes in your family or home environment that may have affected your child: ____
____

IV. ADDITIONAL REMARKS

Please use the remainder of this page to write any additional comments you wish to make regarding your child.