THE SEED SCHOOL OF MIAMI
STUDENT HEALTH INFORMATION FORM

All information in this document will be kept **confidential** within student files in the office of the Director of Student Support Services and shared only amongst the school leadership, and mental/physical wellness staff. Unless otherwise noted specifically noted in a section, all information listed herein is required to be provided.

DEMOGRAPHIC INFORMATION (REQUIRED)

Student's Name	**Date of Birth**	**Age**	**Sex**	**Grade**
Ethnicity	**Religious/Spiritual Affiliation**		**Primary Language at Home**	
Home Address				
Legal Guardian (if different from above)				**Relationship to Student**
Phone (home)		**Phone** (work)		**Phone** (cell)
Address				
Emergency Contact Name				**Relationship to Student**
Phone (home)		**Phone** (work)		**Phone** (cell)

MEDICAL HISTORY (REQUIRED)

(as indicated by both referral source and student/family)

Pediatrician/Primary Care Physician:

Name: _____ Tel: _____

Other Specialists – Allergists, Nutritionists, Psychologist, Psychiatrist, Therapist, etc. who currently work with or have worked with the child in the past.

Name: _____ Specialty: _____ Tel: _____

Name: _____ Specialty: _____ Tel: _____

Name: _____ Specialty: _____ Tel: _____

Name: _____ Specialty: _____ Tel: _____

Name: _____ Specialty: _____ Tel: _____

Case Worker (if applicable)

Name: _____ Agency Name: _____

Office Phone: _____ Cell Phone: _____

E-mail address: _____ Dates of Service (From - To) _____

MEDICAL CONCERNS: List any conditions, illnesses or allergies the child has (Past/Present):

☐ Allergies (please list) _____ _____ _____ _____	☐ Communicable/Infectious Diseases (HIV, Aids, Hepatitis, Measles, Meningitis, Chicken Pox, Salmonella, TB, Sexually Transmitted) (please list) _____ _____ _____	☐ Heart Condition (murmur, arrhythmia) (please list) _____ _____ _____ _____
☐ Asthma or Respiratory Disease	☐ Depression	☐ High Blood Pressure
☐ ADD/ADHD	☐ Diabetes	☐ Juvenile Arthritis or Rheumatoid Diseases
☐ Autism Spectrum Disorders / Sensory Integration Disorder	☐ Learning Disorders	☐ Seizures
☐ Birth Defects (please list)	☐ Fetal alcohol syndrome	☐ Sickle Cell
☐ Bipolar	☐ Physical Impairments or Fractures	☐ Speech/Language Disorders
☐ Cancer	☐ Epilepsy	☐ Traumatic Brain Injury

TOILETING: Does your child have toileting accidents overnight (urinate or defecate) in the bed while sleeping? **Circle** YES NO

HOSPITALIZATIONS OR SURGERIES

AGE ADMITTED	REASON

SEXUAL DEVELOPMENT (if applicable) - The three questions below provide the school with valuable information to assist with program design and student support. They are optional for families to complete.

Indicate age of first menstrual cycle: _____
Sexual involvement: _____
Pregnancies, STDs, etc.): _____

MEDICATION INFORMATION (REQUIRED – if applicable)

Date first prescribed (began to take it)	Prescribing Physician (Doctor's Name, Address & Phone Number)	Pharmacy Name and Phone Number	Name of Medicine	How much is taken? (Dosage)	When is it given? (Schedule)	What is it used for? (Purpose and Diagnosis)	How often do you get need to get a refill? OR New Prescription?

DEVELOPMENTAL HISTORY

The questions below provide the school with valuable information to assist with program design and student support. They are optional for families to complete.

Mother's Pregnancy History

TYPE	YES	NO	COMMENTS
Mom's Prenatal Care			
Physical Health			
Mental Health			
Substance Use			
Complications during pregnancy			
Complications during labor			

Infancy (age 0-2)

TYPE	CONCERN	NO CONCERN	COMMENTS
Typical Development			
Not gaining weight/growing			
Sleep Problems			
Colic			
Surgeries			
Cognitive			
Motor Skills (crawling, walking, grasping, etc.)			
Language Development			
Behavior			
Separation from caregiver			

Preschool (age 2-4)

TYPE	CONCERN	NO CONCERN	COMMENTS
Typical Development			
Speech/Language			
Sleep Problems			
Social Skills			
Surgeries			
Motor Skills (crawling, walking, grasping, etc)			
Cognitive Development			
Toilet Training			
Separation from caregiver			
Behavior			

Childhood (age 5-10) (peer/social relationships, behavior problems; adjustment to school):

TYPE	CONCERN	NO CONCERN	COMMENTS
Typical Development			
Speech/Language			
Sleep Problems			
Social Skills			

Surgeries			
Motor Skills (crawling, walking, grasping)			
Cognitive			
Toileting			
Separation from caregiver			

Adolescence (age 11-18) (mood, behavior problems, self-care/hygiene, peer/social interactions):

TYPE	CONCERN	NO CONCERN	COMMENTS
Typical Development			
Speech/Language			
Sleep Problems			
Social Skills			
Surgeries			
Motor Skills (crawling, walking, grasping)			
Cognitive			
Toileting			
Separation from caregiver			

FAMILY DATA/HISTORY

The questions below provide the school with valuable information to assist with program design and student support. They are optional for families to complete.

Family Members (biological and adoptive parents, siblings, grandparents) **and Significant Persons** (mentors, relatives):

Name	Age	Relationship to Student	Currently lives with student	Level of Education	Occupation/School

Explanation of above/additional information:

Past/Present living arrangements

Living Arrangements	Duration	Sleeping Arrangements	Duration
☐ With Biological Mother or Father (list which)	_____	☐ With relatives (in the past/present)	_____
☐ With Relatives	_____	☐ Sleeps in his own room	_____
☐ Foster or Group Home	_____	☐ Sleeps in his own bed	_____
☐ Residential Placement	_____	☐ Shares a room	_____
☐ Shelter	_____	☐ Shares a bed	_____

Family Strengths:

Family Values, Beliefs, Customs, and Traditions:

Family alcohol/substance use/abuse: (who and for how long)

Family mental/physical health history (depression, schizophrenia, heart disease, cancer):

Health Concern	TYPE (ex: cancer, heart disease, depression, schizophrenia)	RELATION TO THE STUDENT (parent, grandparent, sibling)
Physical (Illness/Disease)		
Mental illness		

STUDENT SOCIAL/EMOTIONAL HISTORY (REQUIRED)

Strengths, hobbies, interests, employment:

Relationships

INDIVIDUAL/TYPE	POSITIVE/YES	NEGATIVE/NO	COMMENTS (who & issues)
Mother			
Father			
Siblings (Brothers/Sisters)			
Other Family Members			
Teachers			
Peers (children of the same age)			
Gangs Involvement/Exposure			
Domestic Violence			

Mood

- ☐ Happy
- ☐ Energetic
- ☐ Angry
- ☐ Depressed
- ☐ Anxious
- ☐ Lonely

Behaviors

- ☐ Loving
- ☐ Active
- ☐ Attentive
- ☐ Oppositional
- ☐ Aggressive
- ☐ Impulsive
- ☐ Self-Injurious (hurts/cuts themselves)
- ☐ Physically or Verbally abusive

Traumatic Events Please indicate who, when and how:

EVENT (witnessing/experiencing)	WHO DID IT INVOLVE?	WHEN DID IT OCCUR?	WHERE DID IT OCCUR?	HOW DID IT OCCUR
Death				
Violence				
Accidents				
Separations (parents/siblings)				

Sexual/physical abuse/assault, neglect. **Please indicate who, when and duration:**

Psychological/Psychiatric services

TYPE OF SERVICE	FROM/TO DATE (DURATION)	AGENCY/ORGANIZATION
Hospitalization or Baker Act		
Individual Therapy		
Family Therapy		
Group Therapy		

STUDENT SUBSTANCE ABUSE HISTORY (REQUIRED)

Drug	First Time Used	Last Time Used	Frequency & Quantity of Use	Methods (smoked, snorted, injected)
Tobacco				
Dippers (PCP)				
Alcohol				
Marijuana				
Cocaine (crack, powder)				
Heroin				
Inhalants				
Ecstasy				

Treatment History:

Additional Information or Comments

_____

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature **Date**