## SPAULDING ACADEMY & FAMILY SERVICES HEALTH SERVICES DEPARTMENT INTAKE/ ADMISSION FORM

Allergies:	Name:		
Date of Birth:	Allergies:		
Date of Birth: Does this student have a history of seizures? No Yes Type: Date of last known seizure:  Prenatal:  Mother received care during what trimester: Was this a planned pregnancy? Yes No List any trauma that occurred during pregnancy: (i.e.: falls, domestic violence, accident) and the dates a treatments:  Trauma Date Treatment  1. 2. 3.  List any complications during pregnancy (prenatal exposure to drugs/alcohol/nicotine, meds and infections): Any history of alcoholism: Amount per day: Any history of drug abuse: Amount per day: Birth History:  Weight: Length: Gestation (weeks): Delivery (vaginal or c-section) Respiratory Status (normal /cyanotic):			
Does this student have a history of seizures?			
Yes Type: Date of last known seizure:  Prenatal:  Mother received care during what trimester: Was this a planned pregnancy? Yes No List any trauma that occurred during pregnancy: (i.e.: falls, domestic violence, accident) and the dates a treatments:  Trauma	Date of Birth:	<del></del>	
Type: Date of last known seizure:  Prenatal:  Mother received care during what trimester: Was this a planned pregnancy? Yes No List any trauma that occurred during pregnancy: (i.e.: falls, domestic violence, accident) and the dates a treatments:  Trauma	•	zures?	No
Mother received care during what trimester:	Type: Date of		
1.  2.  3.  List any complications during pregnancy (prenatal exposure to drugs/alcohol/nicotine, meds and infections):  Any history of alcoholism: Any history of drug abuse: Any history of drug abuse: Amount per day: Amount per day: Birth History:  Weight: Delivery (vaginal or c-section) Respiratory Status (normal /cyanotic):	Mother received care during what trim Was this a planned pregnancy? Ye List any trauma that occurred during p	es No	
2.  3.  List any complications during pregnancy (prenatal exposure to drugs/alcohol/nicotine, meds and infections):  Any history of alcoholism:  Any history of drug abuse:  Birth History:  Weight:  Delivery (vaginal or c-section)  Respiratory Status (normal /cyanotic):  Greenatal exposure to drugs/alcohol/nicotine, meds and infections.  Amount per day:  Amount per day:  Gestation (weeks):  Delivery (vaginal or c-section)	Trauma	Date	Treatment
List any complications during pregnancy (prenatal exposure to drugs/alcohol/nicotine, meds and infections):  Any history of alcoholism: Any history of drug abuse: Any history of drug abuse: Amount per day: Birth History:  Weight: Delivery (vaginal or c-section) Respiratory Status (normal /cyanotic):	1.		
List any complications during pregnancy (prenatal exposure to drugs/alcohol/nicotine, meds and infections):  Any history of alcoholism: Any history of drug abuse: Any history of drug abuse: Amount per day: Birth History:  Weight: Delivery (vaginal or c-section) Respiratory Status (normal /cyanotic):	2		
Any history of alcoholism: Amount per day:  Birth History:  Weight: Length: Gestation (weeks): Delivery (vaginal or c-section)  Respiratory Status (normal /cyanotic):			
List any complications during pregnancy (prenatal exposure to drugs/alcohol/nicotine, meds and infections):  Any history of alcoholism: Amount per day: Amount per day: Birth History:  Weight: Length: Gestation (weeks): Delivery (vaginal or c-section) Respiratory Status (normal /cyanotic):	3.		
Any history of drug abuse: Amount per day:  Birth History:  Weight: Length: Gestation (weeks):  Delivery (vaginal or c-section)  Respiratory Status (normal /cyanotic):		cy (prenatal exp	osure to drugs/alcohol/nicotine, meds and
Weight: Length: Gestation (weeks): Delivery (vaginal or c-section) Respiratory Status (normal /cyanotic):			Amount per day:
Delivery (vaginal or c-section) Respiratory Status (normal /cyanotic):	Birth History:		
Other Complications: B	Delivery (vaginal or c-section) Respiratory Status (normal /cyanotic): Other Complications:		

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## **Past Medication Trials:**

	Medication	Start Date	Treatment for	Stop Date	Prescribing Physic	cian
1						
2						
3						
4						
Present Me	edications:					
	Medication	Start Date	Treatment for	Stop Date	Prescribing Physic	cian
1						
2.						
3						
3						
Developme	ntal History:					
Infant temp	perament/regu	lation (sleep, feed	ling):			
Age Group		Beha	vior Level	***		
Infancy:		Sittin	Sitting w/o assistance:		onth:	
mancy.		Craw				-
		Ciuw	6.			-
Toddler:		First v	words:			_
	First s	sentences:			_	
		Toilet	Training			-
Any curren	nt (or past) phy	sical restrictions	? If so, please desc	ribe:		

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Are there any known health issues in any biological family member?
Mother:
Father:
Sibling:
Aunt(s)
Uncle(s)
Grandparents

IMMUNIZATIONS: \*Please submit latest immunization record upon admission.

## PHYSICIANS/PROVIDERS

	Present	Past
Physician (M.D.):	Name:	Name:
	Address:	Address:
	Phone#:	Phone#:
D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	<b>N</b> T	<b>N</b> 7
Psychologist/Therapist:	Name:	Name:
	Address:	Address:
	Phone#:	Phone#:
	1 поист.	i noneπ.
Dentist:	Name:	Name:
	Address:	Address:
	Phone#:	Phone#:
<b>Orthodontist:</b>	Name:	Name:
*(parent/guardian	Address:	Address:
responsibility)		
	Phone#:	Phone#:
Onton otwist!	Names	Name
Optometrist/	Name: Address:	Name: Address:
Ophthalmologist	Audress:	Audress:
	Phone#:	Phone#:
Please list any visual	1 Hollen.	1 Honen.
impairments		_
-		
<b>Psychiatrist(s):</b>	Name:	Name:
	Address:	Address:
	Phone#:	Phone#:
NT 1 1 4	N	N
Neurologist:	Name:	Name:
	Address:	Address:
	Phone#:	Phone#:
	т поист.	т поист.
Orthopedist:	Name:	Name:
F		
	Address:	Address:
	Address: Phone#:	Address: Phone#:

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Past Placement and Date	tes:			
1.				
2				
J				
Has student ever been s	seen as an out-patient o	or in-patient at Da	rtmouth Hitc	chock Medical Center?
Past Hospitalizations:				
Place	Dates		Reason	
1				
2				
3				
Present Diagnosis:		Physician:		
1				
2				
3				
Forms Completed By:				
	Parent/Guardian		-	Date
	Family Worker		-	Date
	Clinician		-	Date
	Health Services Nur	rse	-	Date
	Admissions		-	Date