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

Name: _____
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 and 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): _____
Other Complications: _____
Apgar Scores: A. _____ B. _____

Past Medication Trials:

	Medication	Start Date	Treatment for	Stop Date	Prescribing Physician
1.					
2.					
3.					
4.					

Present Medications:

	Medication	Start Date	Treatment for	Stop Date	Prescribing Physician
1.					
2.					
3.					
4.					
5.					

Developmental History:

Infant temperament/regulation (sleep, feeding): _____

Age Group	**Behavior Level**	What month:
Infancy:	Sitting w/o assistance:	_____
	Crawling:	_____
Toddler:	First words:	_____
	First sentences:	_____
	Toilet Training	_____

Any current (or past) physical restrictions? If so, please describe:_____
_____
_____

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#:**
Psychologist/Therapist:	**Name:**	**Name:**
	Address:	**Address:**
	Phone#:	**Phone#:**
Dentist:	**Name:**	**Name:**
	Address:	**Address:**
	Phone#:	**Phone#:**
Orthodontist: ***(parent/guardian responsibility)**	**Name:**	**Name:**
	Address:	**Address:**
	Phone#:	**Phone#:**
Optometrist/ Ophthalmologist	**Name:**	**Name:**
	Address:	**Address:**
	Phone#:	**Phone#:**
Please list any visual impairments		
Psychiatrist(s):	**Name:**	**Name:**
	Address:	**Address:**
	Phone#:	**Phone#:**
Neurologist:	**Name:**	**Name:**
	Address:	**Address:**
	Phone#:	**Phone#:**
Orthopedist:	**Name:**	**Name:**
	Address:	**Address:**
	Phone#:	**Phone#:**

Past Placement and Dates:

1. _____ _____
2. _____ _____
3. _____ _____

Has student ever been seen as an out-patient or in-patient at Dartmouth Hitchock Medical Center?
___ Yes ___ No

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 Nurse	_____ Date
_____ Admissions	_____ Date