TEXAS SCHOOL FOR THE BLIND AND VISUALLY IMPAIRED

STUDENT MEDICAL / DIETARY HISTORY FORM

Information for Parent: So that we can safely care for your child, please provide complete and specific information on every question. If a section does not apply, you must check that there are no such conditions before going to the next section. Please return this completed form to your V.I. teacher and they will enter the information into our system directly. This form is required for every student without exception, even if the student already attended TSBVI at an earlier time.

Student Name: _____ Today's Date: _____ Date of Birth:

STUDENT MEDICATIONS

If your child is accepted, he or she must bring
all prescription medications in their original pharmacy container.

Prescription Medication			
Prescription	Dosage	When to Administer (Frequency & Time)	Reason for Medication

Vitamins and Other Supplements			
Name	**Dosage**	**When to Administer (Frequency & Time)**	**Reason for Vitamin**

EYES

Please describe your child's eye condition, including when it began or when you became aware of it, and how your child is affected by the vision loss, to the best of your knowledge. (Example 1: My child has retinitis pigmentosa. My child began to lose his vision at age 16. He has lost most of his vision but still has some central vision. Example 2: I do not know the cause of my child's vision problems. She seems to see some light.)

☐ Describe below any conditions or any changes:

☐ No eye conditions (Go to next Section: Communicable Diseases)
No eye conditions (Go to next Section: Communicable Diseases)

Please check below

My child has glasses:	☐ Yes	☐ No
My child has contact lenses:	☐ Yes	☐ No
If yes, in which eye(s)?	☐ Right Eye	☐ Left Eye
My child has prosthetic (artificial) eyes:	☐ Yes	☐ No;
If yes, which eye(s):	☐ Right Eye	☐ Left Eye
Does your child have Retinal Precautions?	☐ Yes	☐ No
Retinal Precaution Details:		

CONDITIONS AND DISEASES (PAST AND CURRENT)

➔ You do not need to include any information about medications or vitamins. Information about medications and vitamins will be covered in a later section.

COMMUNICABLE DISEASES

☐ My child has none of the following conditions.

Name of Condition or Disease	Has the student had the disease?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information.
Chickenpox (varicella)	☐ Yes ☐ No	
Mumps	☐ Yes ☐ No	
Measles (rubella)	☐ Yes ☐ No	
Scarlet Fever	☐ Yes ☐ No	
Rheumatic Fever	☐ Yes ☐ No	
Diptheria	☐ Yes ☐ No	
Whooping Cough	☐ Yes ☐ No	
Meningitis	☐ Yes ☐ No	
Encephalitis	☐ Yes ☐ No	
HIV	☐ Yes ☐ No	
AIDS	☐ Yes ☐ No	
Cytomegalovirus (CMV)	☐ Yes ☐ No	
Hepatitis A	☐ Yes ☐ No	
Hepatitis B	☐ Yes ☐ No	
Hepatitis C	☐ Yes ☐ No	
Hepatitis (other form): _____	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No	

GASTROINTESTINAL

☐ My child has none of the following conditions.

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information (e.g., Colostomy, Urostomy, feeding, "G" Tube)
Chewing or Swallowing Problems	☐ Yes ☐ No	
Frequent Diarrhea	☐ Yes ☐ No	
Frequent Constipation	☐ Yes ☐ No	
Recurring Hemorrhoids	☐ Yes ☐ No	
Encopresis (involuntary bowel movement)	☐ Yes ☐ No	
Other:		

Tube Feeding

☐ **My child does not require tube feeding**

Information about Tube Feeding	Please tell us what staff needs to know about tube feeding so that we can care for your child properly and safely.
Frequency; how often?	
Quantity: How much food? Number of ounces?	
Procedure	
"Push" or Gravity Driven?	
Position of child during feeding? After feeding?	
For how long is special positioning needed after feeding?	
Give water in tube afterward?	
Is any oral intake allowed? Under what circumstances?	

MUSCLE, BONE

☐ No needs in this area

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information (e.g., orthopedic aids: walker, wheelchair, cane)
Joint Pain or Stiffness	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	
Missing Arm, Leg, Finger, Toe	☐ Yes ☐ No	
Other:		

RESPIRATORY

☐ No needs in this area

Type of Problem	Does the Student Have a Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information (e.g., tracheotomy)
Frequent Colds, Coughs, Sore Throats	☐ Yes ☐ No	
Pneumonia	☐ Yes ☐ No	
Bronchitis	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Reactive Airway Disease	☐ Yes ☐ No	
Other:		

BLOOD, HEART, AND CIRCULATORY

☐ No needs in this area.

Type of Problem	Does the Student Have a Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information (e.g., Stint)
Prolonged Bleeding	☐ Yes ☐ No	
Bruises Easily	☐ Yes ☐ No	
Heart Problem	☐ Yes ☐ No	
Hemophilia	☐ Yes ☐ No	
Hypertension	☐ Yes ☐ No	
Sickle Cell Disease	☐ Yes ☐ No	
Other:		

Has your child ever had a blood transfusion? ☐ Yes ☐ No
If yes, please describe circumstances:

ENDOCRINE

☐ No needs in this area.

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Thyroid or Pituitary Problems	☐ Yes ☐ No	
Acanthosis Nigricans (define?)	☐ Yes ☐ No	
Diabetes Type I or II	☐ Yes ☐ No	
Diabetes Insipidus	☐ Yes ☐ No	
Hypoglycemia	☐ Yes ☐ No	
Other:		

SKIN

☐ No needs in this area.

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Eczema	☐ Yes ☐ No	
Other:		

NERVOUS SYSTEM, NEUROLOGICAL

☐ No needs in this area.

Type of Problem	Does the Student Have a Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Information
Seizures	☐ Yes ☐ No	Date of Last Seizure _____ Description of Seizures:

		Frequency: _____ Medication: ☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	
Cystic Fibrosis	☐ Yes ☐ No	
Muscular Dystrophy	☐ Yes ☐ No	
Multiple Sclerosis	☐ Yes ☐ No	
Paralysis	☐ Yes ☐ No	
Traumatic Brain Injury (TBI)	☐ Yes ☐ No	
Tourette's Syndrome	☐ Yes ☐ No	
Other:		
If you checked "yes" in any box, has your child ever had a neurological exam? If so, when:		
Does your child have a shunt? ☐ Yes ☐ No If yes, ☐ Right ☐ Left ☐ Both Sides Is the shunt(s) currently functioning? ☐ Yes ☐ No		

BLADDER, KIDNEY, LIVER

☐ No needs in this area

☐ Describe below any conditions or any changes:

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Urination Problems (pain, burning, frequency)	☐ Yes ☐ No	
Bedwetting	☐ Yes ☐ No	
Enuresis (involuntary urination)	☐ Yes ☐ No	
Other:		

CANCER

☐ No needs in this area.

Type	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Leukemia	☐ Yes ☐ No	

Retinoblastoma	☐ Yes ☐ No	
Other:		

ALLERGIES		
☐ No needs in this area.		
Type of Problem	**Does the Student Have a Problem in This Area?**	**How Does Your Child React to Allergies Checked? Does Child Use an "EpiPen"?** ☐ Yes ☐ No
Environmental/Seasonal Allergies	☐ Yes ☐ No	
Insect Allergies	☐ Yes ☐ No	
Medical Allergies	☐ Yes ☐ No	

ALLERGIES (continued)	
Food Allergies	will be described in a later section
Other:	

EAR		
☐ No needs in this area.		
Type	**Does the Student Have a Problem in this Area?**	**Describe Complications, Long-Term Effects, Ongoing Treatment or Other Information**
Ear Infections	☐ Yes ☐ No	
Needs earplugs when swimming	☐ Yes ☐ No	
Other:		

BEHAVIORAL, PSYCHOLOGICAL, PSYCHIATRIC		
☐ No needs in this area.		
Type	**Does the Student Have a Problem in This Area?**	**Describe Effects of This Condition**
Attention Deficit (Hyperactivity) Disorder (ADD; ADHD)	☐ Yes ☐ No	

Autism	☐ Yes ☐ No	

MISCELLANEOUS		
☐ No needs in this area.		
Type	**Does the Student Have this Problem?**	**Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information**
Frequent Headaches	☐ Yes ☐ No	
Dizziness	☐ Yes ☐ No	
Fainting	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No	
Unusual Weight Gain or Loss	☐ Yes ☐ No	
Problems with Appetite	☐ Yes ☐ No	
Other:		

MENSTRUAL

☐ No needs in this area.

For students who have menstrual periods:

Are they regular?
☐ Yes: How often do they occur (e.g., every 28 days) ____
☐ No: Describe:

Does your daughter take any medications to control menstrual pain, to regulate hormones, for birth control, or for any other use related to menstruation? Yes ☐ No ☐ Describe:

Does your daughter need any assistance in order to manage her menstrual needs? Yes ☐ No ☐
If so, please describe:

Describe any other information that might be useful to school staff:

DENTAL

☐ No needs in this area.

Type	Does the Student Have this Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Information
Problems with Teeth	☐ Yes ☐ No	

Problems with Gums	☐ Yes ☐ No	
Dental Retainer or other appliance	☐ Yes ☐ No	
Other:		

DIET AND EATING

PROHIBITED AND/OR LIMITED FOOD AND DRINK

☐ No needs in this area.

Type of Food and/or Drink that is Prohibited, Restricted or Limited	Reason	Directions, Comments
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other	
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other	
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other	

REQUIRED FOOD, DRINK AND/OR SUPPLEMENT (NOT INCLUDING VITAMINS)

☐ No needs in this area.

Type of Food, Drink and/or Supplement that is Required	Reason	Directions, Comments
	☐ Medical Condition ☐ Other	
	☐ Medical Condition ☐ Other	
	☐ Medical Condition ☐ Other	

SPECIAL FOOD PREPARATION

☐ No needs in this area.

Required Bite Size, Food Consistency, or Preparation

Requires food cut to the following bite size: ☐ 1/8 “ ☐ 1/4" ☐ 1/2”	Comments:
Requires food of the following consistency: ☐ mashed/ground (like mashed potatoes) ☐ pureed (like baby food or apple sauce) ☐ liquified or almost liquefied (like syrup, honey, cream)	Comments:

Other Food Preparation Needs:

ADDITIONAL INFORMATION RELATED TO DIET OR EATING

☐ No additional information
☐ Additional Information
Describe Here:

OTHER MEDICAL INFORMATION

If there is any medical issue that you have not addressed or fully addressed above (e.g., any other type of medical procedure, surgery, injury, treatment) please provide additional information here:

PARTICIPATION IN PHYSICAL ACTIVITIES

TSBVI students may be scheduled to participate in activities such as walking, running, jumping, climbing, skating, trampoline, bicycle riding, weight lifting, ball sports, swimming, and other water activities.

Does your child have any restrictions or need any special assistance (other than support for vision loss) when participating in physical activities (e.g., limited physical stamina, potential for retinal detachments):

☐ My child can participate in physical activities with no restrictions
☐ My child has the following restrictions with regard to physical activities:

SWIMMING

Student Skills Assessment Prior to Any Swimming Activity. Prior to participating in any instructional or recreational swimming activity, each student will be required to take a swimming skills test given by a TSBVI Lifeguard. Student swimming activities will be provided based on the student skills as determined by the assessment.

Student with Seizure Disorder. Any student with any type of seizure disorder (other than in infancy only) is required to wear a life jacket during all recreational and instructional swim activities except when the student is within immediate physical reach of a staff member whose only responsibility during the time that the student is not wearing a life jacket is to supervise the student.

An exception to this requirement can be requested in the following limited situations: students in grades 6-12 who are participating in either a Short-Term Program class or an academic summer program (Academic Secondary Enrichment or SWEAT), who have not had a seizure within the past three years, may waive the life jacket requirement by completing the "Life Jacket Waiver" form. This form requires the written approval of the student's parent and physician, stating that the student may safely participate in swimming activities in a swimming pool without wearing a life jacket (see form for more specific information). The form will be part of the application packet for appropriate programs.

MEDICAL INSURANCE

What type of medical insurance does your child have?

☐ None

☐ Medicaid; Recipient Number: Case Number:

☐ Other: Name of Insurance Company:

Name of Policy Holder: Policy Number:

MEDICAL PROVIDERS

Primary Care Doctor:

Phone Number:

Address:

Specialty Doctor (if applicable)**:**

Phone Number:

Area of Specialty:

Address:

PERMISSION TO CONTACT MEDICAL/DENTAL PROVIDERS

During the course of caring for your child, it may be necessary or beneficial for TSBVI to contact one or more of the above-listed medical providers. Please indicate below whether you give TSBVI permission to contact the provider.

I give permission for TSBVI to contact any of the above-listed medical providers ☐ Yes ☐ No

PERMISSIONS

Staff Administration of Student Medication on Fieldtrips

☐ Yes ☐ No I give permission for a TSBVI staff member who is not a licensed nurse or doctor to administer my child's medicine on field trips according to the medical instructions provided by the prescribing physician.

Comment (if desired):

Routine Medical And Health-Related Evaluation; Treatment of Minor Injuries and Illnesses

☐ Yes ☐ No I give permission for the above-named student to receive routine medical and health-related evaluation and treatment of minor injuries and illnesses including physician-prescribed medication and non-prescription medication.

Comment (if desired):

Emergency Medical and Surgical Treatment

☐ Yes ☐ No I give permission for my child to receive emergency medical and surgical treatment determined necessary by an attending physician. I understand that the Texas School for the Blind and Visually Impaired will make every reasonable

effort to contact me before any prescriptions, doctor appointments or emergency treatment is administered.

In the event that further permission is needed during such treatment, please contact the following person who has the authority to make medical decisions for the student:

Name:

Relationship to Student: ☐ Parent ☐ Guardian ☐ Foster Parent

Home Phone:

Work Phone:

Cell Phone:

Comment (if desired):

Blood Testing

☐ Yes ☐ No In the event a staff member or student is exposed to my child's blood or body fluids, I give permission for TSBVI to conduct a blood test on my child for infectious diseases.

Comment (if desired):

I, _____ , verify this information is correct and up to date on _____
Parent, Guardian or Student (18 yrs. of age or older) — Date

TVI Name: _____ (For verifying information was provided to you by the above signed.)