Texas School for the Blind and Visually Impaired

Medical Dietary History

Student's Name:_____ **Gender:**_____

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

It is important for us to have complete information about each student's medical conditions and dietary information. **Please provide complete and specific information on every question. This form is required of every student without exception, even if the student already attended TSBVI at an earlier time.** Thank you for your patience and thoroughness!

Medications

If student does not take medication, please check: ☐ Student does not take medication.

If student does take medication: Please take the "Health Care Provider's Order for Student Medication" form to the student's physician's office and have one of the approved staff listed on the form complete and sign the form.

Eyes

Please describe student's eye condition, including when it began or when you became aware of it, and how student is affected by the vision loss, to the best of your knowledge.

Example 1: Student has retinitis pigmentosa. Student 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 Student's vision problems. She seems to see some light.

Student has glasses. ☐ Yes ☐ No

Student has contact lenses. ☐ Yes ☐ No
If yes, which eye(s): ☐ Right Eye ☐ Left Eye

Does student need assistance with contact care? ☐ Yes ☐ No
If yes, please describe below:

Student has prosthetic (artificial) eyes. ☐ Yes ☐ No

If yes, which eye(s): ☐ Right Eye ☐ Left Eye

Does student need assistance with prosthetic care? ☐ Yes ☐ No
If yes, please describe below:

Student has glaucoma. ☐ Yes ☐ No

Does the student have an Aqueous (Ocular) shunt? ☐ Yes ☐ No
If yes, which side is the shunt located? ☐ Right ☐ Left
If yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.

Does student have any of the following eye conditions? (check all that apply)

- ☐ Retinopathy of Prematurity (with functional vision, i.e. more than just light perception)
- ☐ Coloboma (bilateral)
- ☐ High myopia
- ☐ Toxoplasmosis
- ☐ Posterior vitreous detachment
- ☐ Diabetes - if related to Glaucoma
- ☐ Glaucoma - if using pilocarpine eye drops, or if the Glaucoma is related to Diabetes, or is indicated by eye doctor
- ☐ Uveitis - chronic eye infection
- ☐ Marfan syndrome
- ☐ CHARGE syndrome
- ☐ Any history of retinal detachment
- ☐ X-Linked Juvenile Retinoschisis
- ☐ Coats Disease

The above eye conditions are associated with increased risk of retinal detachment. To ensure student's safety, TSBVI places the following retinal precautions for students with one or more of these conditions.

"Student is at risk for retinal detachment. Student may not participate in activities likely to cause a blow or jarring to the head. Such activities include, but are not limited to, cheerleading, trampoline, jumping rope, gymnastics, water or snow skiing, contact sports (such as soccer, football, martial arts, basketball, or wrestling), and sports with flying projectiles (such as goal ball, tennis, baseball, volleyball or softball). Student may not dive headfirst into a pool or body of water. Staff should notify the Health Center immediately if student complains of sudden changes in vision, seeing flashes, an increase or development of floaters, or any other changes in peripheral vision."

Please describe any additional precautions TSBVI staff needs to take because of student's visual problem.

Conditions and Diseases (Past and Current)		
Name of Condition or Disease	**Has student had the disease?**	**If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.**
Chickenpox (varicella)	☐ Yes; Year: _____ ☐ No	
Mumps	☐ Yes; Year: _____ ☐ No	
Measles (rubella)	☐ Yes; Year: _____ ☐ No	
Measles (rubeola)	☐ Yes; Year: _____ ☐ No	
Scarlet Fever	☐ Yes; Year: _____ ☐ No	
Rheumatic Fever	☐ Yes; Year: _____ ☐ No	
Diphtheria	☐ Yes; Year: _____ ☐ No	
Whooping Cough	☐ Yes; Year: _____ ☐ No	
Meningitis	☐ Yes; Year: _____ ☐ No	
Encephalitis	☐ Yes; Year: _____ ☐ No	
HIV	☐ Yes; Year: _____ ☐ No	
AIDS	☐ Yes; Year: _____ ☐ No	
Cytomegalovirus (CMV)	☐ Yes; Year: _____ ☐ No	
Hepatitis A	☐ Yes; Year: _____ ☐ No	
Hepatitis B	☐ Yes; Year: _____ ☐ No	
Hepatitis C	☐ Yes; Year: _____ ☐ No	
Hepatitis (other form):	☐ Yes; Year: _____ ☐ No	
Tuberculosis	☐ Yes; Year: _____ ☐ No	

Gastrointestinal	
☐ **Student has none of the following conditions.**	
Type of Problem	**If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information (for example, Colostomy, Urostomy).**
Frequent Diarrhea ☐ Yes ☐ No	
Frequent Constipation ☐ Yes ☐ No	
Recurring Hemorrhoids ☐ Yes ☐ No	
Encopresis (involuntary bowel movement) ☐ Yes ☐ No	
Other:	

Respiratory

☐ **Student has none of the following conditions.**

Type of Problem		If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information (for example, Tracheotomy, Respirator).
Frequent Colds	☐ Yes ☐ No	
Pneumonia	☐ Yes ☐ No	
Bronchitis	☐ Yes ☐ No	
Asthma or Reactive Airway Disease	☐ Yes ☐ No	**Does student use an emergency inhaler?** ☐ Yes ☐ No
Cystic Fibrosis	☐ Yes ☐ No	
Sleep Apnea	☐ Yes ☐ No	

Other:

Blood, Heart, Circulatory

☐ **Student has none of the following conditions.**

Type of Problem		If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information (for example, Stint, Pacemaker).
Prolonged Bleeding or Hemophilia	☐ Yes ☐ No	
Bruises Easily	☐ Yes ☐ No	
Heart Problem	☐ Yes ☐ No	
Hypertension	☐ Yes ☐ No	
Sickle Cell Disease	☐ Yes ☐ No	

Other:

Muscle, Bone

☐ **Student has none of the following conditions.**

Type of Problem		If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.
Joint Pain/Stiffness/Arthritis	☐ Yes ☐ No	
Missing Arm, Leg, Finger, Toe	☐ Yes ☐ No	
Limited Muscle Control/Tone Issues limiting sitting balance or arm/leg movement	☐ Yes ☐ No	

Other:

Orthopedic and Adaptive Equipment

☐ **Student has none of the following conditions.**

Orthopedic and Adaptive Equipment		**Please explain below what staff needs to know related to any orthopedic or adaptive equipment student uses or needs to use.**
Special Bath Equipment/Benches	☐ Yes ☐ No	
Support Cane/Crutches	☐ Yes ☐ No	
Bracing	☐ Yes ☐ No	
Ankle-Foot Orthotic (AFO)	☐ Yes ☐ No	
Walker	☐ Yes ☐ No	

Does student need assistance with any adaptive equipment (e.g., putting on an AFO or brace)? ☐ Yes ☐ No

Wheelchair ☐ Yes ☐ No

If student uses a wheelchair, please provide the following additional information:

Manual ☐ Power ☐ or Both ☐ Comments: _____

Any special transfer equipment or technique? ☐ Yes ☐ No Comments: _____

Any special concerns for bus or van travel? ☐ Yes ☐ No Comments: _____

Can child negotiate bus/van steps with help and travel in the vehicle seat? ☐ Yes ☐ No Comments: _____
_____

Does child require a wheelchair lift vehicle? ☐ Yes ☐ No Comments: _____
_____

After entering vehicle, can child transfer to and ride in vehicle seat? Or does the child need to ride in the wheelchair?
☐ Vehicle Seat ☐ Wheelchair Comments: _____

Travel with Special Orthopedic Equipment:
Which <u>one</u> statement best describes student's ability to travel using special orthopedic equipment?

☐ Is totally dependent on adult to push/drive wheelchair or to steer walker, support cane or crutches

☐ Manages school/campus travel using equipment, but must have adult assistance within arm's reach for safety purposes

☐ Manages school/campus travel using equipment, but must have adult assistance within sight/hearing distance to verbally give direction

☐ Is able to travel safely with orthopedic equipment, staying on sidewalks, avoiding obstacles, people, and drop-offs (curbs), requiring minimal adult supervision

Endocrine

☐ **Student has none of the following conditions.**

Type of Problem		If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.
Hyperthyroidism	☐ Yes ☐ No	
Hypothyroidism	☐ Yes ☐ No	
Hypopituitarism	☐ Yes ☐ No	
Panhypopituitarism	☐ Yes ☐ No	
Growth Hormone Imbalance	☐ Yes ☐ No	
Acanthosis Nigricans	☐ Yes ☐ No	
Diabetes Type I	☐ Yes ☐ No	
Diabetes Type II	☐ Yes ☐ No	
Diabetes Insipidus	☐ Yes ☐ No	
Hypoglycemia	☐ Yes ☐ No	
Adrenal Insufficiency	☐ Yes ☐ No	If Yes, does student require Solu-Cortef in emergencies? ☐ Yes ☐ No

Other:

Skin

☐ **Student has none of the following conditions.**

Type of Problem	If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.
Eczema	☐ Yes ☐ No

Other:

Cancer

☐ **Student has none of the following conditions.**

Does student currently have, or have they ever had, any form of cancer? ☐ Yes ☐ No

If Yes, describe type of cancer, complications, long-term effects, ongoing treatment or other important information:

If in remission, for how long?

Bladder, Kidney, Liver

☐ **Student has none of the following conditions.**

Type of Problem		If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.
Urination Problems (pain, burning, etc.)	☐ Yes ☐ No	
Bedwetting	☐ Yes ☐ No	
Incontinence Enuresis (involuntary urination)	☐ Yes ☐ No	

Other:

Nervous System, Neurological

☐ **Student has none of the following conditions.**

Does the student have a ventricular shunt? ☐ **Yes** ☐ **No** ☐ **If yes,** ☐ **Right** ☐ **Left** ☐ **Both Sides**

Is/Are the shunt(s) currently functioning? ☐ **Yes** ☐ **No**

Type of Problem		**If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.**
Seizures	☐ Yes ☐ No	Date of Last Seizure: Description of Seizure: **Does student use Diastat?** ☐ **Yes** ☐ **No**
Cerebral Palsy	☐ 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 selected "yes" to any of the above, has the student ever had a neurological exam? ☐ Yes ☐ No
If so, when:

Non-Food Allergies

☐ **Student has none of the following conditions.**

Type of Problem	**Describe complications, long-term effects, ongoing treatment or other important Information.**
Food**:** Please tell us about student's food allergies in the "Diet and Eating" section beginning on page 10.	
Does or has the student used an epi-pen? ☐ Yes ☐ No	
Environmental Allergy (ex. mold, dust, plants, trees): ☐ Yes ☐ No If yes, explain and describe below.	
Insect, Spider, Animal Allergy: ☐ Yes ☐ No If yes, explain and describe below.	
Medication Allergy: ☐ Yes ☐ No If yes, explain and describe below.	
Latex, Fragrances, Lysol or Other Allergy: ☐ Yes ☐ No If yes, explain and describe below.	

Ear	
☐ **Student has none of the following conditions.**	
Type of Problem	**If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.**
Hearing Problem ☐ Yes ☐ No	
Hearing Aids ☐ Yes ☐ No	If yes, which ear(s)? ☐ Right ☐ Left ☐ Both Does student need assistance with care of aids? ☐ Yes ☐ No If Yes, Please explain.
Cochlear Implants ☐ Yes ☐ No	If yes, which ear(s)? ☐ Right ☐ Left ☐ Both Does student need assistance with cochlear implants? ☐ Yes ☐ No If Yes, Please explain.
Frequent Ear Infections ☐ Yes ☐ No	
Other:	

Behavioral, Psychological	
☐ **Student has none of the following conditions.**	
Type of Condition or symptoms	**If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.**
Attention Deficit Disorder (ADD) or (ADHD) ☐ Yes ☐ No	
Autism ☐ Yes ☐ No	
Depression ☐ Yes ☐ No	
Bipolar Disorder ☐ Yes ☐ No	
Anxiety / Panic attacks ☐ Yes ☐ No	
Obsessive Compulsive Disorder ☐ Yes ☐ No	
Post-Traumatic Stress Disorder ☐ Yes ☐ No	
Suicidal Ideation / Behaviors ☐ Yes ☐ No	
Sleep disturbances ☐ Yes ☐ No	
Conduct disorder (aggressive, destructive, or deceitful behaviors) ☐ Yes ☐ No	
Verbal Aggression ☐ Yes ☐ No	
Physical Aggression ☐ Yes ☐ No	

Behavioral, Psychological Continued		
Psychotic disorder	☐ Yes ☐ No	
Hallucinations	☐ Yes ☐ No	
Alcohol / Substance abuse	☐ Yes ☐ No	
Other:		

Dental	
☐ **Student has none of the following conditions.**	
Type of Condition	**If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.**
Problems with Teeth or Gums ☐ Yes ☐ No	
Dental Retainer/Braces ☐ Yes ☐ No	If Yes, Which one?
Other:	

Menstrual

☐ **Student does not menstruate.**

For students who have menstrual periods:

Are they regular?

☐ Yes: How often do they occur? (for example, every 28 days) _____

☐ No: Describe:

Does student take any medications to control menstrual pain, to regulate hormones, for birth control, or for any other use related to menstruation?

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

Miscellaneous

☐ **Student has none of the following conditions.**

Type of Problem	**If Yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.**
Frequent Headaches ☐ Yes ☐ No	
Frequent Dizziness or Fainting ☐ Yes ☐ No	
Problem with Weight Gain/Loss/Appetite ☐ Yes ☐ No	
Other:	

Diet and Eating

Eating and Swallowing Difficulties

☐ **Student has no eating or swallowing difficulties.**

☐ Does student cough, clear his/her throat, or choke when he or she swallows? ☐ Yes ☐ No

If yes, please explain**:**

☐ Does student experience a running nose or tearing eyes associated with a swallow? ☐ Yes ☐ No

If yes, please explain:

☐ Has student ever had a swallowing evaluation done by an Occupational Therapist or Speech Pathologist?

If yes, what test was performed? _____ Date of most recent test: _____

☐ Has student ever had a Modified Barium Swallow Study (MBSS-video x-ray of the swallow)? ☐ Yes ☐ No

If yes, when was the study performed?

☐ Has student ever had swallowing therapy? ☐ Yes ☐ No

If yes, when was the study performed (approximate date range)?_____ to_____

Special Modifications

☐ **Student has no need for special modifications**

Modification		**If Yes, please tell us what staff needs to know about any modification so that student may eat properly and safely.**
Positioning	☐ Yes ☐ No	
Postural supports during or after eating	☐ Yes ☐ No	
Aspiration	☐ Yes ☐ No	
Choking Risk (due to over-stuffing, big bites, or eating too fast)	☐ Yes ☐ No	
Chewing	☐ Yes ☐ No	
Swallowing	☐ Yes ☐ No	
Adaptive Equipment and Special Eating Supplies (adapted plates, cups, bowls, spoons, forks, knives)	☐ Yes ☐ No	
Frequency of Eating	☐ Yes ☐ No	
Liquids During or Between Meals	☐ Yes ☐ No	

Other:

Special Food and Drink Preparation

☐ **Student has no need for special food preparation—food consistency, bite size or preparation.**

Student requires food of the following size and consistency:

☐ chopped (regular consistency chopped to 1/2" bite size)

☐ soft solid (easy to chew, can cut with the side of a fork such as baked fish)

☐ mechanical ground (very finely chopped to 1/4" bite size such as chili)

☐ Pureed: (blended foods, mashed potatoes, applesauce, scrambled eggs)

Why does student need this special food size/consistency? _____

Who recommended it and when? _____Do you have a prescription from a doctor for this diet? ☐ Yes ☐ No

☐ **Student has no need for special liquids preparation.**

Student requires liquids thickened to the following consistency: ☐ nectar ☐ honey ☐ pudding

Why does student need this special liquids consistency?

Who recommended it and when?

Tube Feeding

☐ **Student 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 student 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?	

Required Food, Drink and/or Supplement (Not Including Vitamins)		
☐ **Student has no required food, drink, or supplements.**		
Type of Food and/or Drink that is Required	**Reason**	**Please Explain (Directions, Comments)**
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other:	
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other:	
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other:	

Prohibited Food and Drink		
☐ **Student has no food or drink prohibitions.**		
Type of Food and/or Drink that is Prohibited	**Reason**	**Please Explain (Directions, Comments)**
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other:	
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other:	
	☐ Allergy ☐ Weight Control ☐ Religious ☐ Other:	

SWIMMING
Does student need to use earplugs when swimming? ☐ Yes ☐ No

Student Skills Assessment Prior to Any Swimming Activity. Prior to participating in any 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 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 some limited situations. Parent/guardian/adult student/other person with legal authority of students in grades 6-12 or adult students 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/guardian/adult student/other person with legal authority 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). This form is available on request from the STP Admissions Office stpadmissions@tsbvi.edu or (512) 206-9241.

We have a separate permission form related to swimming activities.

By signing this form, I confirm that all data has been reviewed and is correct to the best of my knowledge.

_____

Signature of Parent or Guardian or
Student age 18 or older who is able to give informed consent or
Other Person with Legal Authority (Power of Attorney, Voluntary Adult Caregiver, or Agent)

_____ _____

Printed Name of Person Signing Date

PLEASE COMPLETE LAST PAGE FOR MEDICAL PROVIDER AND INSURANCE INFORMATION

Medical Insurance.

What type of medical insurance does student have?

☐ None

☐ Medicaid; Recipient Number:_____ Case Number:_____

☐ Other: Name of Insurance Company:_____

Name of Policy Holder:_____

Policy Number:_____

Student Medical and Dental Providers.

Primary Care Doctor: _____ Phone Number: _____

Area of Specialty: Primary Care Fax Number: _____

Address: _____

Last Seen: _____

Date of Next Recommended Visit: _____

Eye Doctor:_____ Phone Number: _____

Area of Specialty: Eye Fax Number: _____

Address:_____

Last Seen:_____

Date of Next Recommended Visit:_____

Dentist: _____ Phone Number:_____

Area of Specialty: Dentistry Fax Number:_____

Address:_____

Last Seen: _____

Date of Next Recommended Visit:_____

Specialty Doctor:_____ Phone Number:_____

Area of Specialty: _____ Fax Number:_____

Address: _____

Last Seen:_____

Date of Next Recommended Visit:_____

Specialty Doctor:_____ Phone Number:_____

Area of Specialty: _____ Fax Number:_____

Address:_____

Last Seen:_____

Date of Next Recommended Visit:_____