Texas School for the Blind and Visually Impaired

Medical Dietary History

Student's Name:_____

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!

Recent Hospitalizations

Has student been hospitalized during the last 12 months? ☐ Yes ☐ No

If yes, please explain:

Medications

Does student take medication? ☐ Yes ☐ No

If yes, please list all medications including over-the-counter meds such as multivitamins and as-needed medications PRN).

Medication Name and Strength/Concentration	Dosage	Time to be Given	How is it Taken (mouth, eye, ear, nose, skin, etc.)	Reason/Medical Condition for which Medication is given

Eyes

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 explain:

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

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

Does student need assistance with prosthesis care? ☐ Yes ☐ No
If yes, please explain:

Does 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 an 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 explain additional precautions TSBVI staff needs to take because of student's visual problem:

Ears

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

Type of Ear Condition

Hearing Problem ☐ Yes ☐ No

If yes, please explain complications, long-term effects, ongoing treatment, or other important information.

Hearing Aids ☐ Yes ☐ No

If yes, which ear(s)? ☐ Right ☐ Left ☐ Both

Does the student need assistance with the care of aids? ☐ Yes ☐ No

If yes, please explain:

Cochlear Implants ☐ Yes ☐ No
If yes, which ear(s)? ☐ Right ☐ Left ☐ Both
Does the student need assistance with cochlear implants? ☐ Yes ☐ No
If yes, please explain:

Frequent Ear Infections ☐ Yes ☐ No
If yes, please explain:

Other- please explain:

Behavioral, Psychological

☐ **Student has none of the following conditions.**
Has the student had any of the following conditions? (check all that apply)

☐ Anxiety
☐ Alcohol / Substance Abuse
☐ Attention Deficit Hyperactivity Disorder (ADHD)
☐ Autism Spectrum
☐ Bipolar Disorder
☐ Conduct Disorder (aggressive, destructive, or deceitful behaviors)
☐ Depression
☐ Eating Disorder
☐ Hallucinations
☐ Obsessive Compulsive Disorder (OCD)
☐ Panic Attacks
☐ Physical Aggression
☐ Post-Traumatic Stress Disorder (PTSD)
☐ Psychotic Disorder
☐ Self-Harm Behaviors
☐ Somatic Complaints
☐ Suicidal Ideation
☐ Verbal Aggression

Other:

If yes to any of the above conditions, please provide information about ongoing treatment or other important supportive information.

Sleep Patterns

Does the student have difficulty with sleep?

Sleep disturbances	☐ Yes ☐ No
Difficulty falling asleep	☐ Yes ☐ No
Waking during the night	☐ Yes ☐ No

If yes, please explain:

Conditions and Diseases (Past and Current)

Name of Condition or Disease	**Has student had the disease?**	**If yes,** please explain complications, long-term effects, ongoing treatment, or other important information.
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 complications, long-term effects, ongoing treatment or other important information (for example, Colostomy, Ileostomy).
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 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	**If yes,** does student require: **Rescue/Emergency Inhaler** ☐ Yes ☐ No **Nebulizer Treatment** ☐ 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 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

Joint Pain/Stiffness/Arthritis ☐ Yes ☐ No

If yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.

Missing Arm, Leg Finger, Toe ☐ Yes ☐ No

If yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.

Limited Muscle Control/Tone Issues limiting: sitting, balance, or arm/leg movement ☐ Yes ☐ No

If yes, please explain. Describe complications, long-term effects, ongoing treatment or other important information.

Other:

Orthopedic and Adaptive Equipment

☐ Student has none of the following conditions.

Special Bath Equipment / Benches ☐ Yes ☐ No

Please explain what staff need to know related to orthopedic or adaptive equipment that the student uses or needs to use.

Support Cane / Crutches ☐ Yes ☐ No

Please explain what staff need to know related to orthopedic or adaptive equipment that the student uses or needs to use.

Bracing ☐ Yes ☐ No

Please explain what staff need to know related to orthopedic or adaptive equipment that the student uses or needs to use.

Ankle-Foot Orthotic (AFO) ☐ Yes ☐ No
☐ Right
☐ Left
☐ Bilateral

Please explain what staff need to know related to orthopedic or adaptive equipment that the student uses or needs to use.
Comment:

Walker ☐ Yes ☐ No

If yes, will the student be bringing a walker to TSBVI ☐ Yes ☐ No
Comment:

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

Wheelchair ☐ Yes ☐ No
If the student uses a wheelchair, please provide the following additional information:
☐ Manual ☐ Power ☐ Both

Comment:

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

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

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

Does the student require a wheelchair lift vehicle? ☐ Yes ☐ No
Comments:

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

Travel with Special Orthopedic Equipment

Which **one** statement best describes the student's ability to travel using special orthopedic equipment?

☐ Is totally dependent on an adult to push/drive the wheelchair or to steer the 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 directions.

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

☐ Drop-offs (curbs), require minimal adult supervision.

Endocrine

☐ **Student has none of the following conditions.**		
Type of Problem		**If yes,** please explain 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 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**, please 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 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 Problems		**If yes,** please explain complications, long-term effects, ongoing treatment or other important information.
Seizures	☐ Yes ☐ No	Date of Last Seizure: Description of Seizure: **Does student have emergency medication?** ☐Valtoco ☐Diastat ☐Nayzilam ☐Clonazepam ☐Lorazepam ☐Other: **Does the student have a functioning Vagal Nerve Stimulator (VNS)?** ☐ 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:		

Headaches, Migraines, Dizziness, Fainting-Formatting issues (used to be called Miscellaneous)

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

Type of Problem		If yes, please explain complications, long-term effects, ongoing treatment or other important information.
Frequent Headaches	☐ Yes ☐ No	
Migraines	☐ Yes ☐ No	
Frequent Dizziness or Fainting	☐ Yes ☐ No	
Other:		

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 or Drink: Please tell us about student's food or drink allergies in the "Diet and Eating" section.	
Does or has the student used an Epi-Pen? ☐ Yes ☐ No **For what allergy does the student have an Epi-Pen?**	
Environmental Allergy ☐ Yes ☐ No (eg. mold, dust, plants, trees): If yes, explain.	
Insect, Spider, Animal Allergy ☐ Yes ☐ No If yes, explain.	
Medication Allergy ☐ Yes ☐ No If yes, explain.	
Latex, Fragrances, Lysol or Other Allergy ☐ Yes ☐ No If yes, explain.	

Dental

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

Condition		If yes, please explain complications, long-term effects, ongoing treatment or other important information.
Problems with Teeth or Gums	☐ Yes ☐ No	
Braces/Dental Retainer	☐ 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? ☐ Yes ☐ No

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

Diet and Eating

Weight Issues

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

Problem with Weight Gain/Loss/Appetite ☐ Yes ☐ No

If yes, please explain and include ongoing treatment or other important supportive information.

Eating and Swallowing Difficulties

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

Does student cough, clear their throat, or choke when they swallow? ☐ 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?
☐ Yes ☐ No

If yes, what test was performed? _____

Date and location 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 and where was the study performed? _____

Has student ever had swallowing therapy? ☐ Yes ☐ No

If yes, when and where was the therapy done (approximate date range)?

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 consistency:

☐ **SOFT & BITE SIZED**- Soft + Bite-sized, tender and moist throughout. Chewing ability needed. Can be mashed with a fork and food does not return to original shape. Bites are no larger than the width of a fork. (IDDSI Level 6)

☐ **MINCED & MOIST**- Very soft, small moist lumps, minimal chewing ability needed. Biting is not required. Particle sizes are small enough to fit through the prongs of a fork. (IDDSI Level 5)

☐ **PUREED**- Smooth with no lumps, not sticky, no chewing ability needed. Usually eaten with a spoon. Sits in a mound on a fork and does not flow through. (IDDSI Level 4)

☐ **LIQUIDISED**- Can be eaten with a spoon or drunk from a cup. Cannot be eaten with a fork because it slowly drips through. Effort needed to drink this through a wide straw. Smooth with no lumps. (IDDSI Level 3)

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/formula? Number of ounces?	
Procedure	
Gravity or Pump Feed?	
For how long is special positioning needed after feeding?	
Water flush or bolus after tube feeding?	
Is any oral intake allowed? Under what circumstances?	

****Please note if student's g-tube comes out, tube will be reinserted to maintain patency. The student will be transported to a hospital for further medical treatment.**

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 Admissions Coordinator 512-206-9182.

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

Emergency Pick-Up Plan

TSBVI may need a responsible person to travel to Austin to pick up your student due to a medical, emotional or behavioral reason or in the event that the student has an emergency hospitalization or treatment. Please provide your plan and possible alternative options for picking up the student immediately if needed. For example, you may say Plan A is that parents will travel to Austin, Plan B may be an uncle who can travel, and Plan C might be a family friend that is available to help.

Plan "A" for Emergency Student Pick-Up:

Name of person responsible: _____

Person's relationship to the student: _____

Phone number: _____

Email: _____

Plan "B" for Emergency Student Pick-Up:

Name of person responsible: _____

Person's relationship to the student: _____

Phone number: _____

Email: _____

Plan "C" for Emergency Student Pick-Up:

Name of person responsible: _____

Person's relationship to the student: _____

Phone number: _____

Email: _____

PLEASE COMPLETE NEXT 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:_____

Permission to Contact Medical/Dental Providers

I give permission for TSBVI to contact any of the above-listed medical providers: ☐ yes ☐ no

Staff Administration of Student Medication on Fieldtrips

I give permission for a TSBVI staff member who is not a licensed nurse or doctor to administer student's medicine on field trips according to the medical instructions provided by the prescribing physician: ☐ yes ☐ no

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

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. ☐ yes ☐ no

Emergency Medical and Surgical Treatment

I give permission for student 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: ☐ yes ☐ no

Blood Testing

In the event a staff member or other student is exposed to this student's blood or body fluids, I give permission for TSBVI to conduct a blood test on student for infectious diseases. ☐ yes ☐ no