GOTTSCHALL ACCESS PROGRAM
MEDICAL HISTORY/FAMILY PROFILE– 2016-2017

Last Name (print) **First Name** Middle Initial (Maiden) Home Phone

Address City State Zip

_____/_____/_____ Sex: M___ F___
Date of Birth

Current Medications/Drugs:

_____ _____

_____ _____

Family History:

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Spouse					
Children					
Brother(s)					
Sister(s)					

Student's Personal History:	**Yes**	**No**
Cardiac Device	___	___
VNS Device	___	___
Down Syndrome	___	___
Prader Willi	___	___
Seizure Disorder	___	___
Encephalopathy	___	___
PDD	___	___
Autism	___	___
Asperger's Syndrome	___	__
Hearing Impairment	___	___
Visual Impairment	___	___
Legally Blind	___	___
Fetal Alcohol Syndrome	___	___
Anxiety	___	___
Depression	___	___
Schizophrenia	___	___
OCD	___	___
Delusions/Hallucinations	___	___
ADHD/ADD	___	___
Bipolar	___	___

Allergies	**Yes**	**No**
Allergies continued:		
Bees	___	___
Foods (list below)	___	___
Animals (list below)	___	___
Latex	___	___
Drug Allergies (list below)	___	___

	Yes	No
Student carries an Epipen	___	___

Food Allergies: _____

Animal Allergies: _____

Drug Allergies: _____

Other/Comments:_____

_____

_____

Signature of Student or Parent/Guardian

Date

Community Autism Resources
A place to start...A presence on your journey.