

46-AIF-MNT
State Inst Gen



CARL H. SWANSON
DIRECTOR

State of Minnesota
Department of Social Security
Division of Public Institutions
Globe Building - 4th and Cedar
St. Paul 1

August 28, 1946

D. Kennedy
per [unclear]

Dr. E. J. Engberg
Superintendent
School for Feeble-minded
Faribault, Minnesota

My dear Dr. Engberg:

We are almost out of the blank "Additional Information at Time of Entering Institution". In view of the fact this was made before the "Medical Examination for Entrance", I am wondering whether there is sufficient additional information to make it advisable to have this form as well as the medical examination and social information that we are now asking for all entrance.

We are also nearly out of the blank for the pregnant woman. I presume that is rather definitely necessary.

I am sending copies of all the blanks in order that you may suggest what you need so that if we should have more printed they will be of the type to be most useful to you.

Very truly yours,

Division of Public Institutions
Carl H. Swanson, Director

By *Mildred Thomson*
Mildred Thomson (Miss)
Head, Bureau for Feeble-minded
& Epileptic

MTbs

cc- Ramsey County Welfare Board



ADDITIONAL INFORMATION AT TIME OF ENTERING INSTITUTION
(To be used only if committed 6 months or more before entrance)

RECORD SINCE COMMITMENT

NAME _____ COUNTY _____

(Please star (*) verified information)

CHECK ILLNESSES:

Chicken Pox	<input type="checkbox"/>	Mastoiditis	<input type="checkbox"/>	Typhoid Fever	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>
Grippe	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Small Pox	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	Tonsilitis	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>

SURGERY

Operation	Date	Place	Doctor	Remarks

VACCINATIONS

For	Date	Result
Small Pox		
Diphtheria		
Typhoid		

LABORATORY TESTS

WASSERMAN		SMEARS		MANTOUX	
Date	Result	Date	Result	Date	Result

ANTILUETIC TREATMENT

Syphilis _____

Gonorrhea _____

PHYSICAL HANDICAPS

MENSTRUAL IRREGULARITIES

MENTAL CHARACTERISTICS
(Exhibited or accentuated)

BEHAVIOR

Temper Tantrums _____	Stealing _____	Promiscuity _____
Extreme depression _____	Run Away _____	Masturbation _____
Suicidal tendencies _____	Assault _____	Homosexuality _____
Others _____	Truancy _____	Sodomy _____
	Sex acts with young girls _____	
	Sex acts with young boys _____	

OTHER INFORMATION

Nearest relative _____ Address _____

Institutional support paid by whom? _____

Correspondent after entrance _____ Address _____

MEDICAL EXAMINATION FOR ENTRANCE TO:

Name Sex Birthdate

Weight Height or body length Temp. Pulse B.P.

Appearance and General Condition

CONDITION AND PHYSICAL FINDINGS: (Note positive findings)

Skin and Mucous Membranes

.....	Abdomen
Head	External Genitals
(Fontanelles, if infant)	Herniae
Eyes	Pelvic Organs
Ears	Muscles
Hearing	Bones & joints
Nose & Throat	(Atrophy, Paralysis, etc.)
Neck	Convulsions
(Thyroid, Lymphatics, etc.)	Size & Shape of Pupils
Thorax
Breasts	Reaction to light & accommodation
Lungs
Heart	Deep Reflexes
	Babinski Romberg

NOTE ESSENTIAL ABNORMALITIES: (Such as: Type of paralysis, Mongoloid facies, Hydrocephalus, Deformities, Allergy, etc.)

DATE AND RESULT OF LABORATORY FINDINGS:

X-ray of Lungs
(Send film to Tuberculosis Control Unit,
Div. of Public Institutions,
Globe Bldg., St. Paul 1, Minn.
Nose & Throat Smear
Blood for Wasserman
Blood for Widal
(Send above specimens to Minn. Dept. of Health,
indicating name and institution to be entered)

Urinalysis: Date
Reaction
Color
Sp. Gravity
Albumin
Sugar
R. B. C.
W. B. C.
Casts

Smallpox Vaccination: Date Result

Other Immunizations, Laboratory Examinations, Date & Kind

DIAGNOSIS:

..... M. D.

DATE 1946
(Address)

INFORMATION TO BE SECURED BY WELFARE BOARD
FROM RELATIVES, BOARDING HOME, OR HOSPITAL
FOR ENTRANCE TO

NAME DATE

DIET (if bottle fed, give formula)

.....

.....

CONVULSIONS:

Severity

Frequency

Medication

LACK OF BOWEL OR BLADDER CONTROL

.....

DEGREE OF HELPLESSNESS: (Such as: Is a bed patient, can sit on the floor or chair; or if ambulatory, note if able to climb stairs)

.....

.....

HYPERACTIVITY: (Explain)

.....

DESCRIBE ANY ABNORMAL BEHAVIOR, INCLUDING DESTRUCTIVENESS, OR UNUSUAL CARE WHICH PATIENT REQUIRES:

.....

.....

.....

.....
 (Source of Information)

.....
 Executive Secretary

By:
 (Worker Securing information)

.....
 Minn.
 County Welfare Bd.

(ADD ON REVERSE SIDE ANY ADDITIONAL PERTINENT INFORMATION)

INFORMATION ON PREGNANT WARDS ENTERING INSTITUTION

NAME _____ COUNTY _____

MenstruationDate when 1st began _____ frequency of periods _____ duration _____
amount _____ Date of first day of last menstruation _____Previous PregnanciesNumber full term _____ Number premature _____
Type of delivery No. normal _____ No forceps _____ No Caesarean _____
Information concerning nursing of infant - only last 2
(Date of Birth (How long (Supplementary (Why not
(of infant (nursed (feeding (nursed
_____Miscarriages or abortionsNumber _____ stage of gestation 1. _____ cause 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____Father or alleged father (encircle which)Name _____ Date of birth _____ Birthplace _____
Color _____ Occupation _____ Present address _____
Shall father have permission to see child and visit mother? _____Baby - legitimate or illegitimate (encircle which)Is baby to remain with mother on discharge from hospital? _____
If not, what is to be the final disposition of baby? _____Report of tests and of antiluetic treatment given & number by which reported to Board of Health

	Date	Result		Treatment
		Positive	Negative	
Wasserman				
1. _____				
2. _____				
3. _____				
4. _____				
Smear for Gonorrhea				
1. _____				
2. _____				
3. _____				
4. _____				

Minimum layette to be furnished by county

3 shirts	1 large blanket to wrap baby
3 pairs of stockings	1 small blanket
3 bands	slip and dress for going home to fit
3 cotton flannel gowns	infant six months of age
24 diapers	1 cap and coat for child three to
3 small mouthed nursing bottles	six months old
3 cotton dresses	

Date filled in _____