Menands Union Free School District
19 Wards Lane, Menands, NY 12204
Phone: 518-465-4561 Fax: 518-434-2840

STUDENT HEALTH HISTORY

Name: _____ Age: _____ Birthdate: _____

Address: _____ Phone Number: _____

Parent/Guardian: _____ Relationship: _____

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Family Physician _____ Phone Number: _____

If your child has ever had any of the following, please give date(s)

_____ Birth/Congenital Defects
_____ Diabetes
_____ Epilepsy (seizures)
_____ German Measles (Rubella)
_____ Measles
_____ Mumps
_____ Asthma
_____ Heart Disease
_____ Heart Murmur
_____ Tuberculosis
_____ contact with TB
_____ Pneumonia
_____ Scarlet Fever
_____ Nephritis (Kidney disease)
_____ Missing Organs (eye, kidney, testicle)
_____ Ear Conditions
_____ Poliomyelitis
_____ Frequent Headaches
_____ Migraines
_____ Rheumatic Fever
_____ Whooping cough
_____ Chicken Pox
____ Head Injury/Concussion

If you answered "yes" to any of the above, please explain: _____

_____

Does this child have any allergies? ❑ Yes ❑ No
If "yes", please list: _____
Has the allergy required emergency treatment? ❑ Yes ❑ No
If "yes", please explain: _____

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No
If "yes", please describe: _____

Is there a history of any past concussions/ head injuries? ❑ Yes ❑ No
If "yes", please describe: _____

Does this child take any medication regularly at home? ❑ Yes ❑ No
Require medication at school? ❑ Yes ❑ No
If "yes", please describe: _____

Does this child have Orthodontic Appliances? (Bridges, braces, plates, capped teeth) ❑ Yes ❑ No
Does this child wear: Eye Glasses ❑ Yes ❑ No ❑ reading only ❑ board work only ❑ all the time
Does this child have any prosthetic devices: ❑ Hearing Aid ❑ Leg Braces ❑ Walker ❑ Wheelchair

Please list any additional concerns or information:

_____

_____

_____

_____

❑ Reviewed with School Nurse Date: _____