Menands Union Free School District
19 Wards Lane, Menands, N.Y. 12204 Ph:
518-465-4561 x 109   Fax: 518-888-3283
School Nurse: Diane Roseberger R.N.

STUDENT HEALTH HISTORY

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian:	Home Phone: Cell Phone:	Date:

Check all that applies:	**YES**	**NO**	**If Yes, please explain and include date:**
Ongoing medical condition	☐	☐	
Followed by medical specialist	☐	☐	
Allergies: *If medication is prescribed please indicate below.	☐	☐	☐ Food_________ ☐ Environmental ☐ Insect ☐ Medication ☐ Other (Explain)
Hospitalization	☐	☐	
Surgery	☐	☐	
Injury that required an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Bone/muscle injury	☐	☐	
Loss of consciousness, concussion or serious head injury.* Please indicate approximate date.	☐	☐	
Convulsion/seizure	☐	☐	
Vision impairment or condition	☐	☐	☐ Glasses ☐ Contacts ☐ Prosthesis
Hearing impairment or condition	☐	☐	☐ Hearing aid ☐ Cochlear implant
Dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition
(Depression, ODD, OCD, anxiety, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition

Please list any additional concerns: (use back of sheet if necessary) ____

CURRENT MEDICATIONS **(Include as needed medications for allergies)**	**YES**	**NO**	**Please list medication name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐ Insulin/blood glucose monitoring ☐ Inhaler/nebulizer ☐ Special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐No ☐Yes: ____

Parent/Guardian Signature:____Date:___________________