



Welcome to the Menands School District! Please complete one packet for each child you are registering.

**PROOF OF RESIDENCY:** When you register by appointment, the parent (s) or person(s) in parental relation to the child will be required to submit (3) forms of documentation establishing residency in the school district, including but not limited to, the following:

- A copy of a residential lease; deed; or mortgage statement
- A statement by a third-party landlord, owner, or tenant from whom the parent(s)/guardian(s) lease from or live with (notarized affidavit)
- Such other statement(s) by a third party establishing the physical presence of the parent(s)/guardian(s) in the school district.
- Pay stub
- Income tax form
- Utility or other bills
- Membership documents based upon residency (e.g. library cards)
- Voter registration document(s)
- Official driver's license, learner's permit, or non-driver ID
- State or other government-issued identification
- Documents issued by federal, state, or local agencies
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

The Menands School District will make a residency determination based upon the material provided by the parent(s)/guardian(s).

**PROOF OF AGE:** To determine a student's age, a certified transcript of a birth certificate or record of baptism, (including a certified transcript of a foreign birth certificate or record of baptism) is required. If such documents are not available a passport would be accepted.

**HEALTH REQUIREMENTS:** NY Public Health Law §2164(7) (a) states no child can be admitted to attend school, for more than fourteen days, without certification provided as evidence of the child's immunization against polio, mumps, measles, diphtheria, rubella, varicella, hepatitis B, pertussis, tetanus, and where applicable Haemophilus influenza type b (Hib) and pneumococcal disease. If the parent is transferring from out-of-state or another country and can show a good faith effort to get the necessary certifications the 14 days can be extended to not more than 30 days. Each new entrant is also required by NY Public Health Law to submit proof of a health examination which shall not be more than (12) months before the commencement of the school year.

Once you have all the required documentation, you're ready to register your child. Please contact Trish



**Menands Union Free School District**  
19 Wards Lane, Menands, NY 12204 | 518-465-4561 | [www.menands.org](http://www.menands.org)

O'Connell at [toconnell@menands.org](mailto:toconnell@menands.org) or 518-465-4651 ext 101 to make an appointment.

When all paperwork has been submitted, reviewed, and determined complete, you will be notified with your child's start date, teacher assignment, and transportation information.

Sincerely,

Trish O'Connell  
Menands UFSD Registrar

<b>Department</b>	<b>Contact</b>	<b>Phone Number</b>	<b>Email</b>
Registration & Transportation	Trish O'Connell	518-465-4561 ext 101	toconnell@menands.org
McKinney Vento Liaison & Special Education	Audrey Koslowski	518-465-4561 ext 115	akoslowski@menands.org
Guidance Counselor	Cheri VandenBerg	518-465-4561 ext 156	cvandenber@menands.org
Health Office	Diane Roseberger	518-465-4561 ext 109	droseberger@menands.org
Cafeteria	Mike Tehan	518-465-4561 ext 120	mtehan@menands.org
After School Child Care	CYC	518-438-9596	info@colonieryouthcenter.org



## For Parent/Guardian:

- Proof of Age: Student's Birth Certificate, Baptismal Certificate, or Passport
- Photo ID of parent/guardian registering student (driver's license or passport)
- Proof of Residency: mortgage statement/deed/lease agreement - + 2 additional  
\*An Affidavit of Residency must be filled out and notarized **ONLY IF** the parent/guardian resides in a dwelling that they do not lease or own.
- Residency Questionnaire
- Student Registration Packet
- Home Language Questionnaire
- Authorization for Release of Records
- IEP (if applicable)
- Custody Paperwork (if applicable)
- Dismissal Procedures Form
- Cafeteria Form
- Technology Agreement
- Code of Conduct Agreement
- Immunization Records

## For School Use

- Determine enrollment eligibility OR give 3 days to provide missing information
- McKinney-Vento determination -STAC202 Completed
- Application completed and accepted.
- Application incomplete. Information needed \_\_\_\_\_



**\*The Federal Family Rights and Privacy Act (FERPA) requires schools to have written consent from a parent or legal guardian before releasing educational records\***

Date of Request: \_\_\_\_\_

**STUDENT INFORMATION**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Last School Attended: \_\_\_\_\_

Prior School Phone: \_\_\_\_\_

Prior School Fax: \_\_\_\_\_

**USE AND DISCLOSURE INFORMATION**

I, the undersigned, do hereby authorize \_\_\_\_\_  
*{name of agency or educational institution maintaining records}*

to disclose and deliver the complete education records maintained under the above name including but not limited to the following  
(Please check all that apply):

- Grades and Transcripts
- Psychological & Educational Testing
- Other (specify) \_\_\_\_\_
- School Health Records
- Special Education Records/Most Recent IEP
- Scores (if applicable)
- Discipline

**The education records checked above shall be delivered to:**

**Name:** Menands School Registrar – Trish O’Connell  
**School:** Menands UFSD  
**Address:** 19 Wards Lane  
Menands, NY 12204  
**Phone:** 518-465-4561 ext. 101 **Fax:** (518) 888-3280  
**Preferred Method of Transmission: Email:** [toconnell@menands.org](mailto:toconnell@menands.org)

I understand that the information obtained by the Menands Union Free School District will be treated in a confidential manner under provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances.

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under prior consent for release.

Signature of parent/guardian: \_\_\_\_\_

Date: \_\_\_\_\_



## PROOF OF RESIDENCE FORM

Student's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

### Own or Rent (Please Circle One)

To enroll you must reside in the Menands Union Free School District. Solely owning property or a home does not constitute residency. Proof of residency is required before a student may be registered. Post office boxes will not be accepted. You must provide at least three (3) proofs from the following list. Your name and address must be indicated on these documents and they must be current.

#### One From Below:

Mortgage Statement

Purchase Contract (must contain both the seller's and the purchaser's name and the address of the property to be Purchased)

Lease Agreement (must be current, legal, and valid between owner and renter, must contain the landlord's name, signature, address, and phone number.

#### Two Additional From Below:

Tax Bill

Driver's License

Utility Bill

Car Registration or Insurance ID

Telephone Bill

Credit Card Bill

Cable/TV Bill

This documentation will be retained in the student's file along with other required documents. Your child(ren) **will not** be admitted to the district until these forms have been received and verified.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by: Signature

\_\_\_\_\_  
Date



## Residency Questionnaire

Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Last

First

Middle

Gender:

- Male  
 Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Month      Day      Year

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

*The answer you give below will help the Menands UFSD determine what services you or your child may be able to receive. Under the McKinney-Vento Act, students are entitled to immediate enrollment in school even if they do not have the documents normally required such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.*

*\*The McKinney-Vento Assistance Act of 1987 is a federal law that provides money for homeless shelter programs.*

**Where is the student currently living? – Please check ONE box.**

- In permanent housing  
 In an emergency or transitional shelter  
 In a motel/hotel  
 With another family or person because of loss of housing or economic hardship  
 In a car, park, bus, train, campsite, or abandoned building  
 Other temporary living situations \_\_\_\_\_.

\_\_\_\_\_  
Print name of Parent, Guardian, or student

X \_\_\_\_\_  
Signature of Parent, Guardian, or Student



## AFFIDAVIT OF RESIDENCY – PROPERTY OWNER

(To be filled out if proof of residence cannot be established through other documentation)

I, \_\_\_\_\_ being duly sworn, depose and say: \_\_\_\_\_ and his/her  
(Property Owner) (Name of Parent/Guardian)

child(ren), \_\_\_\_\_, reside at my property located at \_\_\_\_\_.  
(Name of child/ren)

My property is the actual and only residence of the parties named, and they reside there daily, and have so resided there for \_\_\_\_ months.

The sole purpose of this affidavit is to confirm the residence of the parties named so that

\_\_\_\_\_

(Name of child/ren)

can attend the Menands Union Free School District tuition-free.

I understand that the Menands Union Free School District will conduct an Attendance Investigation to verify the residence of the parties named in this affidavit, including a visit to my property.

I also understand that \_\_\_\_\_ is/are not residing at my property solely for the reason of attending school within this district.

Any false statement made in this affidavit may be a crime subject to appropriate penalty as contained within the Penal Law of the State of New York.

I can be contacted at the number(s) listed below should the Menands Union Free School District require further information.

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Primary Property Owner Signature: \_\_\_\_\_

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_

\_\_\_\_\_



Elisa Alvarez, Associate Commissioner Office of  
Bilingual Education and World Languages

55 Hanson Place, Room 594  
Brooklyn, New York 11217  
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB  
Albany, New York 12234  
(518) 474-8775 / Fax: (518) 474-7948

## Home Language Questionnaire (HLQ)

*Dear Parent or Person in Parental Relation:*  
*In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.*

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

### Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	_____	<input type="checkbox"/> Parent 2
		<i>specify</i>	<i>specify</i>
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

### THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT  
INFORMATION SYSTEM:

District Name (Number) & School:

Address:



## Home Language Questionnaire (HLQ)—Page Two

### Educational History

8. Indicate the total number of years that your child has been enrolled in school \_\_\_\_\_

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes\*    No    Not sure  
            \*If yes, please explain: \_\_\_\_\_

How severe do you think these difficulties are?     Minor     Somewhat severe     Very severe

10a. Has your child ever been **referred** for a special education evaluation in the past?     No     Yes\* \*Please complete 10b below

10b. **\*If referred for an evaluation**, has your child ever **received** any special education services in the past?  
 No     Yes – Type of services received: \_\_\_\_\_

Age at which services received (Please check all that apply):  
 Birth to 3 years (Early Intervention)     3 to 5 years (Special Education)     6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?     No     Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

\_\_\_\_\_

\_\_\_\_\_

12. In what language(s) would you like to receive information from the school? \_\_\_\_\_

\_\_\_\_\_  
*Signature of Parent or of Person in Parental Relation*

Month:    Day:    Year:  
 \_\_\_\_\_  
*Date*

Relationship to student:     Parent     Other: \_\_\_\_\_

#### OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

#### NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

ORAL INTERVIEW NECESSARY:     No     Yes

\*\*DATE OF INDIVIDUAL INTERVIEW: \_\_\_\_\_  
 MO.    DAY    YR.

OUTCOME OF INDIVIDUAL INTERVIEW:  
 ADMINISTER NYSITELL  
 ENGLISH PROFICIENT  
 REFER TO LANGUAGE PROFICIENCY TEAM

#### NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

DATE OF NYSITELL ADMINISTRATION: \_\_\_\_\_ PROFICIENCY LEVEL ACHIEVED ON NYSITELL:  
 MO.    DAY    YR.     ENTERING     EMERGING     TRANSITIONING     EXPANDING     COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:



## New Student Registration Form

Menands Union Free School District

19 Wards Lane  
Menands, NY 12204  
Phone: 518-465-4561  
Fax: 518-888-32800

### Student Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Grade: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

#### **Resident Address:**

\_\_\_\_\_ Apt/Room # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is this student a foster child?  Yes If yes, what is the home district: \_\_\_\_\_  
 No If yes, a DSS 2999 Form is required

Check box if for Transportation Only:  School Registering for: \_\_\_\_\_

### Previous Enrollment Information

Former Address (House #, Street, City, State, Zip, Apt #) \_\_\_\_\_ Has this student ever been  Yes  
enrolled in Menands  No

Former School:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Has the child ever been expelled from school?  Yes  No

If yes, give reason: \_\_\_\_\_

### Special Education Needs

Does the child receive special education services?  Yes  No

If so, please place a checkmark next to each service your child is receiving.

<input type="checkbox"/> 1:1 Aide	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Consultant Teacher	<input type="checkbox"/> Extended Test Taking Time
<input type="checkbox"/> BOCES	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Self-Contained Classroom	<input type="checkbox"/> Classroom Aide
<input type="checkbox"/> 504 Plan	<input type="checkbox"/> Speech/Language Therapy	<input type="checkbox"/> Resource Room	<input type="checkbox"/> Declassified

**Health Information**

Family Doctor: \_\_\_\_\_ Hospital: \_\_\_\_\_

Health Care Facility: \_\_\_\_\_ Dentist: \_\_\_\_\_

Please list any treatments, illnesses, accidents, or allergies: \_\_\_\_\_

**Student Race and Ethnicity**

**Please answer questions (1) and (2). Please read them before you respond**

[For question (1) Select the box that best describes your child.] Select only ONE box.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race:     Yes, Hispanic     No, not Hispanic

2. Select ONE or MORE races from the following racial groups.  
[For question (2) you may select all groups that apply to your child. Select at least ONE box.]

- American Indian or Alaskan Native: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. E.g. Cherokee, Mohawk, Inuit.  
Asian:
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Native Hawaiian/Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Black: A person having origins in any of the black racial groups of Africa.
- White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

## Immigration Information

### **For Immigrants Only: (Must answer all 4)**

Years in U.S. schools: \_\_\_\_\_

Country of origin: \_\_\_\_\_

City where born: \_\_\_\_\_

Home language: \_\_\_\_\_

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## Emergency Contacts

List 2 relatives and a neighbor who will be responsible for your child in case of illness/accident and you cannot be reached

- Imperative in the event of an emergency – cannot be Parents

Contact 1: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Contact 1 Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Contact 2: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Contact 2 Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Contact 3: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Contact 3 Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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## Automated Telephone Notification

Please list 2 each: phone numbers, email addresses and cell phones for text messages

**Please Note: This system cannot dial extensions. Therefore, please use numbers that will reach you directly.**

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Email 1: \_\_\_\_\_ Email 2: \_\_\_\_\_

Cell phone 1 for text message: \_\_\_\_\_

Cell phone 2 for text message: \_\_\_\_\_

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## Siblings in Same Household

<u>Name:</u>	<u>Date of Birth</u>	<u>Gender</u>	<u>Grade</u>
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____

\_\_\_\_\_  M  F \_\_\_\_\_  
\_\_\_\_\_  M  F \_\_\_\_\_  
-----

**Other Information**

Has family moved within past 3 years to obtain migratory employment?  Yes  No

- If yes, complete migrant worker form.
- Did your Child Receive Free and/or Reduced lunch in your prior school?  Yes  No

-----  
**Internet Permission**

My child has permission to use the internet at school:  Yes  No

-----  
**Custody**

Is there a custody issue?  Yes  No

If Yes, who has custody? \_\_\_\_\_

**(A copy of the custody papers must be given to the school district at the time of registration and any updates in the future must also be kept on file at the school)**

Is there an order of protection?  Yes  No

**Important: The District shall presume that either parent of the student has the authority to obtain the child's release from school unless provided with legal documentation stating otherwise . . . . .**  
**Adults Authorized to Pick up Children (Other than Parents)**

The following individuals have my permission to pick up my children from school

(\*Please list all individuals including emergency contacts if you so choose. **YOUR CHILD CANNOT BE RELEASED TO OTHER THAN THOSE LISTED.**)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Parent/Guardian Information**

**Parent 1**

Name Prefix:  Dr.  Mr.  Mrs.  Ms.  Other

Name: \_\_\_\_\_

Relationship to Student:  Father  Mother  Step-Father  Step-Mother  Relative  Non-Relative

Legal Guardian  Yes  No

Active Military  Yes  No

Has Custody  Yes  No

Can this person:	Yes	No
Receive mail about this student	<input type="checkbox"/>	<input type="checkbox"/>
Pick up this student from school	<input type="checkbox"/>	<input type="checkbox"/>
Is Active Military	<input type="checkbox"/>	<input type="checkbox"/>
Has custody	<input type="checkbox"/>	<input type="checkbox"/>

Address: \_\_\_\_\_  
(If Different from Student) City State Zip

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone Numbers:  
Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Home: \_\_\_\_\_

Spoken Language: \_\_\_\_\_ Written Language: \_\_\_\_\_

Personal Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

**Parent/Guardian Information**

**Parent 2**

Name Prefix:  Dr.  Mr.  Mrs.  Ms.  Other

Name: \_\_\_\_\_

Relationship to Student:  Father  Mother  Step-Father  Step-Mother  Relative  Non-Relative

Legal Guardian  Yes  No

Active Military  Yes  No

Has Custody  Yes  No

Can this person:	Yes	No
Receive mail about this student	<input type="checkbox"/>	<input type="checkbox"/>
Pick up this student from school	<input type="checkbox"/>	<input type="checkbox"/>
Is Active Military	<input type="checkbox"/>	<input type="checkbox"/>
Has custody	<input type="checkbox"/>	<input type="checkbox"/>

Address: \_\_\_\_\_  
(If Different from Student) City State Zip

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone Numbers:  
Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Home: \_\_\_\_\_

Spoken Language: \_\_\_\_\_ Written Language: \_\_\_\_\_

Personal Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

## Parent/Guardian Information

### Parent 3

Name Prefix:  Dr.  Mr.  Mrs.  Ms.  Other

Name: \_\_\_\_\_

Relationship to Student:  Father  Mother  Step-Father  Step-Mother  Relative  Non-Relative

Legal Guardian  Yes  No

Active Military  Yes  No

Has Custody  Yes  No

Can this person:	Yes	No
Receive mail about this student	<input type="checkbox"/>	<input type="checkbox"/>
Pick up this student from school	<input type="checkbox"/>	<input type="checkbox"/>
Is Active Military	<input type="checkbox"/>	<input type="checkbox"/>
Has custody	<input type="checkbox"/>	<input type="checkbox"/>

Address: \_\_\_\_\_  
(If Different from Student) City State Zip

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone Numbers:

Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Home: \_\_\_\_\_

Spoken Language: \_\_\_\_\_ Written Language: \_\_\_\_\_

Personal Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

**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: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian:	Home Phone: _____ Cell Phone: _____	Date: _____

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

**CHECK ALL THAT APPLY TO YOUR CHILD:**

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

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	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ASSISTIVE EQUIPMENT</b>	<b>YES</b>	<b>NO</b>	<b>Please check all that apply</b>
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other:
<b>TREATMENTS</b>	<b>YES</b>	<b>NO</b>	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Insulin/blood glucose monitoring <input type="checkbox"/> Inhaler/nebulizer <input type="checkbox"/> Special diet

Is there any condition that would prevent your child from participating in physical education or sports?

No Yes: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**MENANDS SCHOOL CAFETERIA PreK 2025-2026**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Circle one: **I do / do not** give permission for my child to purchase snacks using his or her cafeteria account.

**Allergies to Foods**

**Please list below any food allergies your child has**

- None
- Peanut or Nut Allergy
- Other \_\_\_\_\_

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**Special Food Considerations**

**Please check all boxes that apply to your child's dietary needs**

- None
- Gluten Free
- No Pork Allowed
- Vegan
- Vegetarian
- Other: \_\_\_\_\_

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Parent's Signature

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Parent's Printed Name

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Date