Student Health History

Student Name: _____ Date of Birth: _____

Physician Name: _____ Physician's Phone Number: _____

Physician's Address: _____ Date of Last Physical: _____

Allergies: _____

Please check any medical diagnoses for the above named student and explain any additional information in the comments section below:

___Asthma/Respiratory	___Mental Health	___Frequent Headaches	___Dental Issues
___Cardiac History	___ADD/ADHD	___Food Intolerances	___Neurological/Concussion
___Seizure Disorder	___Depression	___Orthopedic Issues	___Renal Issues
___Endocrine/Diabetes	___Anxiety	___Frequent Nose Bleed	___Gastrointestinal Issues
___Vision Issues	___Speech Delays	___Skin Issues/Rashes	___Hearing/Ear Infections

___Other: _____

Has your child had any serious injuries, illnesses, or hospitalizations? If yes, please explain: _____

_____

☐ Check here if your child has a food allergy and needs to sit in a food safe zone.

☐ Check here if your child needs a special diet, and if yes, please explain: _____

☐ Check here if your child has any physical restrictions, if yes, please explain: _____

Please list all medications taken at home: _____

Medications ordered to be taken at school: _____

Comments: _____

_____

_____

New York State law requires that a physician's written prescription and a written permission from the parent/guardian be filed in the health office before your child will be permitted to take medication during school & at all school related activities. Medications must be in the original container with the pharmacy label attached. This also applies to all over the counter medications. Medication must be taken in the health office. Please contact the health office for further information and forms to be completed if necessary.

It is essential that we maintain the safety of your child while he/she is in school, especially with regard to emergency and/or chronic medical condition(s). The medical condition(s) must be confirmed in writing from your child's physician. Medical condition information will only be shared with staff members who interact with your child. Your signature below allows us to share pertinent medical information in written form (name, diagnosis, symptoms of condition, and proper treatment) with school staff. If you have any questions or concerns, please feel free to contact our school nurse(s), Mrs. Gabrielle Gonzalez - (518)734-3400 - ext. 1131 or ggonzalez@wajcs.org or Tracy Selner - ext. 1181 or tselner@wajcs.org

Parent signature: _____ Date: _____