Mamaroneck Union Free School District

STUDENT MEDICAL HISTORY INFORMATION

(To be completed by Parent or Guardian at the beginning of each school year)

Your student's learning depends upon good health. To assist in providing health services at school, please complete the following form. Information is confidential and may be shared with teaching staff as needed. **Return this form to the school nurse as soon as possible.** Thank you.

Student's Name: (Please print) _____ **Date of birth:** _____**Male☐ Female☐**

Grade:_____ **Teacher/Counselor**: _____

School: ☐ Central ☐Chatsworth ☐Mamaroneck Avenue ☐Murray
☐Hommocks ☐High School ☐ Other

Resides with Parent/Guardian Name(s): _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Doctor's name: _____ Date of last physical: _____
Dentist's name: _____ Date of last visit: _____

Is the student under an orthodontist's care? ☐No ☐Yes **Doctor's Name**_____

Birth history: Any complications or problems during pregnancy and/or delivery? ☐No ☐Yes
Please describe: _____

Full term birth? ☐No ☐Yes If no, how premature was the child? ____(weeks). Birth weight: _____lbs. _____oz.

Has the student ever had:	YES	Date:		YES	Date:
Chicken Pox	☐	_____	Meningitis	☐	_____
Encephalitis	☐	_____	Rheumatic Fever	☐	_____
Lyme disease	☐	_____	Positive TB test	☐	_____
Bleeding tendency	☐	_____	Pneumonia	☐	_____
High Blood Pressure	☐	_____	Kidney disease	☐	_____

Any complications from above illnesses? (please explain) _____

Does the student have or had a history of the following?

• Allergies? Yes ☐ To drugs, food, insects, pollen? Please list:_____
Has the allergy required emergency action in the past? No☐ Yes☐
What happens to the student? _____

• Asthma? Yes ☐ Triggered by: _____Treatment: _____
Diagnosed by doctor? _____Date:_____
Uses: inhaler☐ nebulizer☐ other medication☐
Taken: at home only☐ may need medication at school☐

• Attention Deficit Disorder Yes ☐ Is the student currently taking medication? No☐ Yes☐
Name of medication:_____ Dose (mg):_____

OVER PLEASE

How often does he/she take it? _____

• Bee sting allergy Yes ☐ Describe reaction: _____
Difficulty breathing No☐ Yes☐
Need emergency medication? No☐ Yes☐

• Bone, joint problems or broken bones? Yes ☐ Describe: _____
Any physical restrictions? _____

• Diabetes Yes ☐ Requires insulin? No☐ Yes☐ Date Diagnosed: _____

• Dizziness, loss of consciousness, fainting or loss of memory? Yes☐

• Heart condition, murmur, or irregular heart beat? Yes ☐ Describe: _____
Any physical restriction? No☐ Yes☐
What are they? _____ Medication? No☐ Yes☐

• Past history of increase lead levels in the blood? Yes ☐ When? _____ What was the level? _____

• Loss of an eye, kidney, testicle or other organ? Yes ☐ _____

• Previous head injury? Yes ☐ Age: _____ Describe: _____

• Seizures? Yes ☐ Type of seizure: _____
Date of last seizure: _____ Medication: _____
Is the student currently under s a doctor's care for seizure?
No☐ Yes☐

Has the student had any other illness? _____

Does the student take on other daily medication at home? No ☐ Yes ☐ **At school?** No ☐ Yes ☐
Name of medication: _____Reason for taking it: _____

Has the student had any condition which required emergency treatment or hospitalization? No ☐ Yes ☐

If yes, for what?	Age	How long in hospital?	Surgeries?
_____	____	_____	_____

Check off the following health categories/concerns that pertain to the student?

<> Eyes: ☐wears glasses ☐wears contacts: ☐for reading ☐for distance ☐all the time

<> Ears: ☐frequent infections ☐ear tubes present Date: _____
wears hearing aid; ☐ right ear ☐left ear ☐ hearing difficulty: explain: _____

<> Other: ☐nosebleeds ☐requires diapering ☐sleeping difficulties ☐eating too little
☐headaches/migraines ☐requires catheterization ☐dental concerns ☐eating too much
☐bowel ☐bladder ☐bed wetting ☐menstruation ☐phobias

Does the student have any medical, physical, learning, or emotional problems that the school should know about?
(handicaps; parents recently separated; etc.) _____

Has your student been evaluated by any of the following professionals? (in the last 12 months):

☐audiologist ☐occupational therapist ☐psychologist ☐speech/language therapist

☐neurologist ☐physical therapist ☐psychiatrist ☐other: _____

Please list any other health concerns you have for the student? _____

_____

Parent/ Guardian signature Date