QUEENSBURY SCHOOL DISTRICT
HEALTH HISTORY INFORMATION

Teacher _____
Grade _____
Entered _____

Student's Name _____ Birth date _____ Sex ____ Age ____

Home Address _____ Phone _____ Cell Phone(s) _____

Father's Name _____ Father's Occupation _____

Father's Employer _____ Work Phone _____

Mother's Name _____ Mother's Occupation _____

Mother's Employer _____ Work Phone _____

Lives with: ☐ Mother & Father ☐ Mother ☐ Father ☐ Mother/Stepfather ☐ Father/Stepmother ☐ Foster Parents/Guardians

Former Address _____

Former School Name _____ Address _____

Other than parent - in case of emergency - whom can we call?

Name _____ Relationship _____ Phone _____

Student's Physician _____ Phone _____

OTHER HEALTH DATA										
Check yes and add year if your child has had any of these:										
Allergies to:	Yes	Yr	**History of**	Yes	Yr	**Any chronic conditions**	Yes	Yr	**List any Surgery**	Yr
Medications			Asthma			Diabetes				
Foods (milk)			Pneumonia / Bronchitis			Epilepsy				
Peanut Butter			Hearing problems			Heart Disease				
Tree Nuts			Ear infection			Rheumatic Fever				
Bee Sting			Vision problems / glasses							
Environmental			Strep Throat							

Does this student take daily prescription medication; (antibiotics, anti-convulsants, ADHD medications, allergy medication or medication for food or drug reaction. If so, please list:

_____

Please advise school nurse if medication is to be taken at school.

Is there any physical limitations preventing this student from participating in physical education activities? _____

Special health conditions the school should be aware of? If so, please describe: _____

_____

In accordance with NYS Public Health Law, it is required that each child entering school into **Kindergarten** or as a new student to the district have all required immunizations and a physical completed within the past year at the time of entrance. Each child will also be required to have a physical examination in grades 2, 4, 7 and 10. Due to HIPPA and to assist in confirming this information, signing this portion of the document authorizes the health office nurse to communicate with your medical doctor regarding immunization status and physical exam. This authorization will continue in effect until you revoke it in writing. A copy of this form may be accepted instead of the original. Refer to school dsitrict policy for other health requirements.

Date of scheduled physical _____

_____
Parent/Guardian Signature