GATEWAY SCHOOL DISTRICT
Health History

Student's Full Name: _____ Grade: _____
Date of Birth: _____ Address: _____
_____

Gender Male _____ Female_____

Immunizations Required – Attach a Copy of Immunizations

Current Health Problems: _____

Current Medications: _____

Previous Surgeries/Hospitalizations: _____

Food Allergies? ☐ Yes ☐ No
Specify (list)_____ If yes, type of reaction and treatment required: _____

Medication Allergies? ☐ Yes ☐ No
Specify (list)_____ If yes, type of reaction and treatment required: _____

Does the student currently have or a history of:	Yes	No	If yes, please explain
Allergies - Environmental/Season (specify)	☐	☐	
Arthritis/Rheumatic Disease	☐	☐	
Asthma	☐	☐	
Attention Deficit Disorder (ADHD/ADD)	☐	☐	
Autism	☐	☐	
Bee Sting/Insect Allergies (specify)	☐	☐	
Bleeding Disorder or Cooley's Anemia	☐	☐	
Born Prematurely, Developmental, or Speech Delay	☐	☐	
Cancer	☐	☐	
Cardiovascular (Heart) Condition	☐	☐	
Cerebral Palsy	☐	☐	
Diabetes Type 1	☐	☐	
Diabetes Type 2	☐	☐	

Does the student currently have or a history of:	Yes	No	If yes, please explain
Dietary Restrictions	☐	☐	
Drug or Alcohol Issues	☐	☐	
Ear, Nose, Throat Conditions	☐	☐	
Eating Disorder	☐	☐	
Emotional or Mental Health Issues	☐	☐	
Epilepsy/Seizure Disorder	☐	☐	
Gastrointestinal (Stomach) Problems	☐	☐	
Genetic Disorder	☐	☐	
Hearing Deficit	☐	☐	
High Blood Pressure	☐	☐	
Migraines or Headaches	☐	☐	
Muscle Disorder	☐	☐	
Neurological (Concussion/Traumatic Brain Injury)	☐	☐	
Orthopedic (Bone) Disorder	☐	☐	
Physical Restrictions	☐	☐	
Scoliosis	☐	☐	
Skin Conditions	☐	☐	
Spina Bifida	☐	☐	
Tourette's Disease	☐	☐	
Urinary Problems	☐	☐	
Vision Deficit	☐	☐	
Any other conditions not listed	☐	☐	

Any medication to be administered during school hours requires a written physician order and written parent/guardian permission.

It is the responsibility of the parent/guardian to inform the school nurse of any changes in the health condition of the student.

_____ _____

Parent/Guardian Signature Date