GATEWAY UNIFIED SCHOOL DISTRICT
STUDENT HEALTH INFORMATION

STUDENT NAME: _____ SCHOOL: _____ SCHOOL YEAR: _____

GRADE: _____ PARENT NAME: _____ PHONE NUMBER: _____

HEALTH INFORMATION ABOUT YOUR CHILD
******CHECK ONLY THOSE THAT APPLY******

☐ **NO KNOWN HEALTH PROBLEMS**

Indicate all known health problems below that apply:

☐ Allergy, FOOD - If yes describe in space below. Does the student have an Epi-Pen? ☐ **Yes** ☐ **No**
☐ Allergy other than food - If yes describe in space below. Does the student have an Epi-Pen? ☐ **Yes** ☐ **No**
☐ Asthma
☐ Diabetes
☐ Epilepsy
☐ Heart Conditions
☐ Operation, serious injury, or illness
☐ Seizure Disorder
☐ Other - ***Please describe below***

If you indicated that your child has any of the above listed health problems use this space to further explain:

_____

_____

Does your child take medication regularly? *California Education Code §49423: Students taking medication at school need a "School Medication Authorization form" completed every 12 months or before if the prescription changes. This form is available at your child's school and MUST* be on file with the school before taking any medication at school.

☐ **Yes** ☐ **No**

Does your child have any ear/hearing problems?
☐ **Yes** ☐ **No**

Does your child have a speech problem?
☐ **Yes** ☐ **No**

Does your child have a physical handicap?
☐ **Yes** ☐ **No**

Does your child have any eye/site problems?
☐ **Yes** ☐ **No**

If you answered yes to any of the above questions, please use the space below to further explain.

_____

_____

_____

Doctor Name: _____ Doctor Phone Number: _____

Dentist Name: _____ Dentist Phone Number: _____

Medical Insurance: _____ Policy Number: _____