Gateway Lab School Staff Health History

This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.

Staff Name _________________________________ *DOB:* __________ *Grade* _________

Name of your primary care physician ____________________________ *Phone #* ______________________

Date of last physical __________________

Name of your eye doctor _________________________ *Phone #* ___________________

*Date of last eye exam*___________ *Did the physician prescribe glasses?* _____________ *Last eye glass/contact prescription change* _________________

Last Dental Exam _____________ *Name of dentist* ____________________ *Phone #* _________________________

Please indicate if you have difficulty with any of the following conditions and give additional information as needed.

( ) ADHD	( ) Body Piercing/Tattoo	( ) Emotional	( ) Physical Disability
( ) Allergies	( ) Bone/Spine	( ) Hearing	( ) Seizures
( ) Asthma	( ) Bowel/Bladder	( ) Heart	( ) Speech
( ) Behavior	( ) Had Chicken Pox illness	( ) Infections	( ) Surgery
( ) Bleeding	( ) Diabetes	( ) Kidney	( ) Vision

***Other**:*____
____

Do you have allergies to medicine, food, latex or insect bites? How treated? ________________________

____

Have you had any illnesses or conditions surface since school ended in June? Give details and date.

____

Have you had surgery since school ended in June?
____

Have you received any immunizations since school ended in June? Please list below with date:

____

Are you being treated or evaluated for any health conditions? List them below

____

Do you take any daily medications or have any daily treatments?

____

Have you had any emotional upsets since school ended in June? (Moved, death, separation, divorce or other)
____

I give permission for the nurse at Gateway Lab School to give the following medications to me as needed by checked items below:

____*Tylenol* ____ *Motrin* ____*Benadryl* _____*Claritin*____ *Tums* _____ *Cough drops* _____ *Chloraseptic spray* ___

____*Pseudophed (phenylephrine) with Tylenol* ____*Neosporin ointment* ____ *Medi-first cold relief*

Signature____ ***Date*** _________