Campus: _____
SY: _____

Gladewater ISD Health Services
Student Health History

Student's Name_____ Grade _____ Date of Birth _____ Teacher _____
LEGAL Last name First Middle PreK through 5th grade

Please list any other names your child may use or go by: _____**Parent/Guardian Name:_____**

(please list contact numbers in preference of order to be called)

Contact Numbers	Type (residence, cell, business)	Name/Relationship	Place of Occupation
#1		Parent / Guardian -	
#2			
#3			
#4			

Parent / Guardian Email address:_____

NOTIFY OFFICE IMMEDIATELY OF ANY CHANGES TO ABOVE INFORMATION

Please check any of the following health conditions of your child:

Allergies _____

Asthma ___Carries inhaler___	Headaches ____		Scoliosis ___Treatment ____	Seizures _____
Bowel Disorder____	Hyperactivity____	Stomach problems ___	Vision Problems ___ Glasses/Contacts ____	Ear Problems ____ Tubes/dates
Diabetes ____	Insulin Dependent____		Carries Glucometer_____	Heart Disorder ____ Restrictions _____

Other:_____

Medications brought to school must be in the original container and a medical release completed prior to any prescribed medication being administered by school personal. Please fill out a Medication Authorization Form available with the campus secretary or health staff.

Please list any medication used routinely by the student at home or school:

_____
Medication Dose Times

_____
Medication Dose Times

GISD does NOT purchase over-the-counter first aid medications.

Information on this page may be shared with teachers in a 'need to know bases' unless otherwise indicated in writing.

_____
Parent Signature

Updated 5/2011