THE GATEWAY SCHOOL

GATEWAY SCHOOL - HEALTH REPORT

Child's Name_____ **Birth Date**_____

Address - Street_____ **Home Phone**_____

City _____

Mother's Name_____ **Business Phone**_____

Father's Name_____ **Business Phone**_____

Person to contact if parents cannot be reached:

Name_____ **Phone**_____

Pediatrician_____ **Phone**_____

IMMUNIZATION RECORD - approximate date (*We uphold the Pennsylvania Department of Health Regulations and require that all immunizations be up to date.*)

D P T
H I B
Poliomyelitis
Hep B
M M R
tine
varivax
other

Surgeries or serious illnesses

ALLERGIES (Please list type of allergy and possible reaction)

GENERAL HEALTH

RESTRICTIONS OR PRECAUTIONS if any, for school to watch:

_____ has recently been examined by me and is in good health and able to participate in all regular pre-school activities.

Doctor's signature_____ **Date**_____