DISTRICT SCHOOL BOARD OF PASCO COUNTY
STUDENT HEALTH INFORMATION FORM

(To be completed for initial registration and for change in health status)

MIS Form #442
Rev. 5/13

Student______________________________________ School__________________ Date__________________
Last Name First Middle

Student #________________________ Grade______ DOB__________________ Sex: Male_____ Female_____

Does your child have any of the following health conditions or concerns?

1. Allergy to any foods, medications, or insects? ___Yes ___No If yes, list ___________________________
   Reaction: ___Mild ___Severe Needs: ___Epipen ___Benadryl

2. Asthma or wheezing? ___Yes ___No
   If yes, please indicate if uses nebulizer: ___Yes ___No If yes, how often? ___________________________
   If yes, please indicate if uses inhaler: ___Yes ___No If yes, how often? ___________________________

3. Diabetes or high/low blood sugar? ___Yes ___No If yes, list medication/treatment ____________________

4. Epilepsy or convulsion/seizure? ___Yes ___No If yes, list medication/treatment ____________________
   Date of last episode__________________________

5. Recent hospitalization? ___Yes ___No If yes, reason__________________________ Date______________
   If yes, reason__________________________ Date______________

6. Heart murmur or history of heart condition? ___Yes ___No If yes, explain__________________________

7. Serious burn or broken bone? ___Yes ___No If yes, explain__________________________

8. Ear infection or draining ear? ___Yes ___No If yes, explain__________________________

9. Trouble hearing? ___Yes ___No Wears hearing aid: ___Yes ___No
   Should be wearing hearing aid: ___Yes ___No

10. Trouble seeing? ___Yes ___No Wears glasses or contacts: ___Yes ___No
    Should be wearing glasses or contacts: ___Yes ___No

11. Major head injury or concussion? ___Yes ___No If yes, explain__________________________
    ____

12. Kidney or bladder problems? ___Yes ___No If yes, explain__________________________

DISTRICT SCHOOL BOARD OF PASCO COUNTY
STUDENT HEALTH INFORMATION FORM

(To be completed for initial registration and for change in health status)

13. Frequent bed-wetting? ___Yes ___No If yes, explain______________________________

14. Stomach or bowel problems? ___Yes ___No If yes, explain______________________________

15. Trouble sleeping? ___Yes ___No If yes, explain______________________________

16. Hernia or rupture of groin or navel? ___Yes ___No If yes, explain______________________________

17. Trouble with teeth? ___Yes ___No If yes, explain______________________________

18. Anemia or low iron? ___Yes ___No If yes, explain______________________________

19. Attention Deficit Disorder (ADD/ADHD) or hyperactivity? ___Yes ___No If yes, explain____________________
    ____

20. Mental health concerns? ___Yes ___No If yes, explain______________________________

21. Difficulty understanding dangerous situations, wanders or runs away from adults? ___Yes ___No If yes, explain______________________________

Please list any other medicine taken regularly and dosage: ______________________________

____

Are there any special health procedures that should be followed at school? ______________________________

____

Are there any limits on your child's participation in physical education or recess activities due to a health condition?

____

If your child is Medicaid eligible, please provide Medicaid number ______________________________ and name of the Medicaid Insurance Plan ______________________________.

______________________________	______________________________	____________________
Print - Parent/Guardian Name	Parent/Guardian Signature	Date

DISTRIBUTION: This form will be placed in your child's cumulative record.