



## DISTRICT SCHOOL BOARD OF PASCO COUNTY STUDENT HEALTH INFORMATION FORM

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

Last Name First Middle Student # Grade DOB Sex: Male Female.  Does your child have any of the following health conditions or concerns?  Allergy to any foods, medications, or insects? Yes No If yes, list Reaction: Mild Severe	tudent			School	Date_	
Does your child have any of the following health conditions or concerns?  Allergy to any foods, medications, or insects?YesNo If yes, list		ne First	Middle			
Allergy to any foods, medications, or insects?YesNo	tudent #		Grade	DOB	Sex: Ma	le Female
Reaction:MildSevere	oes your child have	any of the following	health conditio	ons or concerns?		
If yes, please indicate if uses nebulizer:YesNo If yes, how often? If yes, please indicate if uses inhaler:YesNo If yes, how often? If yes, please indicate if uses inhaler:YesNo If yes, how often?	. Allergy to any fo	ods, medications, or	insects?	YesNo If y	es, list	
If yes, please indicate if uses nebulizer:YesNo	Reaction:N	fildSevere	Needs: _	EpipenBena	dryi	
If yes, please indicate if uses inhaler:YesNo _ If yes, how often?						
Diabetes or high/low blood sugar?YesNo If yes, list medication/treatment						
Epilepsy or convulsion/selzure?YesNo	If yes, please in	dicate if uses inhaler	:Yes	No If yes, how often	en?	
Date of last episode    Recent hospitalization?YesNo	. Diabetes or high	n/low blood sugar? _	YesN	lo If yes, list medicati	on/treatment	
Recent hospitalization?YesNo   If yes, reason	Epilepsy or con-	vulsion/seizure?	_YesNo	If yes, list medication	n/treatment	
Heart murmur or history of heart condition?YesNo	Date of last epis	sode		_		
Heart murmur or history of heart condition?YesNoNoNoNoYesNoNoNoYesNoNoYesNoNoYesNoYesNoNoYesNoNoYesNoNoYesNoNoYesNoNoYesNoNoYesNoNoYesNoNoNoNoNoNoNo	. Recent hospital	ization?Yes _				
Serious burn or broken bone?YesNo			If yes	, reason		Date
B. Ear infection or draining ear?YesNo If yes, explain	5. Heart murmur o	r history of heart con	dition?Y	esNo If yes, e	xpl <b>ain</b>	
O. Trouble hearing?YesNo Wears hearing aid:YesNo Should be wearing hearing aid:YesNo Wears glasses or contacts:YesNo Should be wearing glasses or contacts:YesNo Major head injury or concussion?YesNo If yes, explain	'. Serious burn or	broken bone?	resNo	If yes, explain		
Should be wearing hearing aid:YesNo  I. Major head injury or concussion?YesNo If yes, explain	3. Ear infection or	draining ear?Y	esNo	lf yes, explain		
No. Trouble seeing?YesNo Wears glasses or contacts:YesNo Should be wearing glasses or contacts:YesNo	9. Trouble hearing	]?YesNo	Wears he	earing aid:Yes	No	
Should be wearing glasses or contacts:YesNo  1. Major head injury or concussion?YesNo If yes, explain			Should be	e wearing hearing aid:	YesNo	
11. Major head injury or concussion?YesNo If yes, explain	.0. Trouble seeing	?YesNo	Wears gla	asses or contacts:	Yes No	
			Should be	e wearing glasses or co	ontacts:Yes _	No
2 Kidney or bladder problems? Ves No If yes explain	I1. Major head inju	ry or concussion?	Yes	No If yes, explain		
2 Kidnov or bladder problems? Ves No If yes explain						
	12 Kidnov or blade	ler probleme?	Ves No	If ves, explain		

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

	Print - Parent/Guardian Name Parent/Guardian Signature Date
the	Medicaid Insurance Plan
lf y	our child is Medicaid eligible, please provide Medicaid numberand name o
Are	there any limits on your child's participation in physical education or recess activities due to a health condition?
Are	there any special health procedures that should be followed at school?
Plea	ase list any other medicine taken regularly and dosage:
21.	Difficulty understanding dangerous situations, wanders or runs away from adults?YesNo If yes, explain
	Mental health concerns?YesNo If yes, explain
19.	Attention Deficit Disorder (ADD/ADHD) or hyperactivity?YesNo If yes, explain
18.	Anemia or low iron?YesNo If yes, explain
17.	Trouble with teeth?YesNo If yes, explain
16.	Hernia or rupture of groin or navel?YesNo If yes, explain
15.	Trouble sleeping?YesNo If yes, explain
14.	Stomach or bowel problems?YesNo If yes, explain
13.	Frequent bed-wetting?YesNo If yes, explain