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_____

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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.