THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA
STUDENT HEALTH QUESTIONNAIRE

The following information is requested by the school nurse to plan an appropriate program for your child's needs in school, should any emergency situation arise. The information provided will be kept confidential in accordance with state and federal law. Please note that:

- **Parent/Guardian is responsible for providing the school with any medication or equipment the student will require during the school day.**
- **If an individual school health care plan is indicated, Parent/Guardian is responsible for providing the school nurse with the necessary medical information**.

Please check with the school's health room to obtain the correct medication and procedure forms.

Parent/Guardian to complete both sides, sign, and return to the school.

Student Information

Student's Name (Last):	Student's Name (First):	Middle initial:	Date of Birth:	Sex: ☐ Male ☐ Female
School:		Grade:	Student's ID:	

Parent Information

Parent/Guardian's Name:		Relationship to student:		Parent/Guardian Name:		Relationship to student:
Home phone #:	Cell phone #:	Work phone #:		Home phone #:	Cell Phone #:	Work phone #:
Emergency Contact Name:		Phone #:		Emergency Contact Name:		Phone #:

My Child has a medical condition that may affect his or her school day. ☐ No ☐ Yes (If yes, continue to Medical Information section.)

I authorize designated Osceola County School District Personnel to exchange medical information as necessary to support the continuity of care of my child. ☐ No ☐ Yes

Parent/Guardian Name (print) _____ Parent/Guardian Signature _____ Date _____

Attention school staff; please return this form to the school nurse.

Medical Information (Complete all boxes that apply to your child)

A. Medical History

☐ Asthma	☐Allergies	☐Heart Disease	☐Diabetes
☐ Seizures	☐Bladder/Kidney problems	☐Sickle Cell	☐ADHD
☐ Vision problems	☐Hearing problems	☐Headaches/Migraines	☐Orthopedic problems
☐ Cancer	☐Hemophilia	☐Other (please specify): _____	

Does your child have a primary care physician? ☐ No ☐ Yes	Name of physician:	Physician's phone #:	Date of last appointment:
Does your child see a specialist? ☐ No ☐ Yes	Name of specialist:	Specialist's phone #:	Date of last appointment:

Does your child require activity restrictions? ☐ No ☐ **Yes (<u>If yes, school must have medical documentation from a provider on file to accommodate any restrictions.)</u>**

B. Medications: Please list all medications your child takes on a daily or as needed basis (A Medication Authorization Form must be obtained from the health room and completed before medications can be dispensed at school.)

Medication Name	How much	Time given	Reason for Medication

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C. Allergies ☐ No ☐ Yes

Are the allergies: ☐ Mild ☐Severe	**What is your child allergic to? (Check all that apply)**	**Please Specify:**
	☐ Foods:	
Date of Last Severe Reaction: ____/____/____	☐ Insect Stings/Bites:	
	☐ Medication:	
Allergy caused by: ☐ ingestion	☐ Plants/Environmental:	
☐ inhalation ☐ contact	☐ Unknown	

Does your child have a food intolerance? If yes, please specify:_____

Please check all symptoms noted with allergic reaction:

☐ Redness ☐ Severe swelling ☐ Itching ☐ Hives
☐ Breathing problems ☐ Swelling of lips/face ☐ Loss of consciousness ☐ Nausea

If your child has a reaction, what do you do to treat the symptoms? _____

*Please list all medications your child takes for allergies in section B.

Has your child been prescribed an epinephrine auto-injector to be used in an emergency? ☐ No ☐ Yes

D. Asthma ☐ No ☐ Yes

Has your child ever been hospitalized due to asthma? ☐ No ☐ Yes If yes, when was last hospitalization?_____

What symptoms does your child experience during an asthma episode?

☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Chest Pain/Discomfort ☐Other: _____

What triggers your child's asthma? (check all that apply)

Trigger:	Please specify/explain:
☐ Exercise	
☐ Environmental	
☐ Foods	
☐ Unknown	
☐ Other	

Currently prescribed medications:

☐ Inhaler (rescue)
☐ Inhaler (controller)
☐ Nebulizer
☐ Oral steroids
☐ Oral antihistamines
*Please list all medications in section B.

E. Diabetes ☐ No ☐ Yes (If yes, please provide a current Diabetes Medical Management Plan from your child's provider.)

Currently prescribed medications and treatments (check all that apply and list medications in section B.)

Insulin via: ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing ☐Glucagon ☐Oral Medications ☐Continuous glucose monitoring

***It is recommended that a complete set of diabetic supplies (insulin, glucagon, fast acting sugar, protein snack, glucometer, etc.) be provided to the school for a student with diabetes even if the student has permission to self-carry these items.**

What symptoms does your child exhibit with **low** blood sugar?	What symptoms does your child exhibit with **high** blood sugar?
Does your child recognize the symptoms of a **low** blood sugar? ☐ No ☐ Yes	Does your child recognize the symptoms of a **high** blood sugar? ☐ No ☐ Yes

F. Seizure Disorder ☐ No ☐ Yes (If yes, please provide a seizure action plan from your child's provider.)

Type of Seizure: ☐ Convulsive ☐ Non-Convulsive Please specify: _____	What symptoms does your child have when having a seizure?		
Date of last seizure:	Length of seizure:	Known triggers:	Has an emergency seizure medication been prescribed by a physician? ☐ No ☐ Yes

Medications: Please list all medication student takes for seizures in section B.

Are any physical activity restrictions required? ☐ No ☐ Yes
***If yes, school must have medical documentation from a provider on file to accommodate any restrictions.**

FOR DISTRICT NURSE USE ONLY: Care Plan ☐ No ☐ Yes Nurse Signature:_____ Date:_____