Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

HEALTH INFORMATION

Complete this form annually to inform us about your student's health condition that affects his or her school day

This form is necessary to inform the Public Health Nurse (PHN) of your child's health status and to plan for health needs that may impact his/her school day. Information is only shared with required school staff as needed. Information provided on this form is protected by the Family Educational Rights and Privacy Act (FERPA) as part of the student's educational record and is securely stored in the health room. For any changes to your student's health condition during the school year or questions regarding this form, please contact the PHN through the health room at your child's school. Contact your child's school front office staff and ask to be connected with the health room.

Section A: Demographics

Student Name: Last	First	Middle	Date of Birth

School Year	School Name	Grade	Teacher	Gender: ☐ Male ☐ Female

Parent/Legal Guardian Name	Home Phone Number	Cell Phone Number	Work Phone Number
Parent/Legal Guardian Name	Home Phone Number	Cell Phone Number	Work Phone Number

Section B: Life Threatening Health Conditions

Does your child have a potentially life threatening health condition to include any of the following?

☐ Diabetes, Type 1 ☐ Seizures requiring rescue medication ☐ Allergy requiring epinephrine ☐ Severe Asthma

Section C: Current Health Conditions

Condition	Check if Yes	Comment
ADD/ADHD	☐	_____ **Provider Diagnosed:** ☐ Yes ☐ No **Under Treatment:** ☐ Yes ☐ No
Allergies		**NOTE: Medication allergies are listed ONLY on Emergency Care Form**
• **Food**	☐	Foods_____ Epinephrine ☐ Yes ☐ No If Yes, Date received _____
• **Food Intolerance**	☐	Foods_____ Gastrointestinal/Digestive Distress ☐ Yes ☐ No Dietary Restriction/Preference ☐ Yes ☐ No
• **Bee Sting-** symptoms ***other*** than local redness/swelling	☐	Epinephrine ☐ Yes ☐ No If Yes, Date received _____
• **Latex**	☐	
Anxiety	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Blood Disorder	☐	
Cancer	☐	Currently Immunocompromised ☐ Yes ☐ No
Dental/Oral Health Condition	☐	
Depression	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Diabetes	☐	Method of Insulin Administration: ☐ Syringe ☐ Pen ☐ Pump
Eating Disorders	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Heart	☐	
Kidney/Urinary Tract Disorders	☐	
Migraines	☐	

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Last Name _____ **First Name** _____ **Date of Birth** _____

Section C: Current Health Conditions Continued

Condition	Check if Yes	Comment
Muscle/Bone/Joint	☐	
Respiratory • **Asthma**	☐	**Triggers:** ☐ **Exercise** ☐ **Environmental** ☐ **Other** _____ **Number of Emergency Room (ER) Visits in the last calendar year:**
• **Cystic Fibrosis**	☐	
• **Lung Disease (other than Asthma)**	☐	**Type** _____ **Date of last episode** _____
Seizure/Neurological	☐	
Skin Condition	☐	☐ **Eczema** ☐ **Other** _____
Stomach/Bowels (IBS, Crohn's etc.)	☐	
Other Health Concerns	☐	
Vision Conditions:	☐	☐ **Contacts/Glasses** ☐ **Non-correctable** ☐ **Other** _____
Hearing Conditions:	☐	☐ **Hearing Aid(s)** ☐ **Other** _____

Section D. Health Procedures

If your child has a health condition, does your child require any health procedures or need any special equipment during the school day?

☐ Yes ☐ No If you answered Yes, please describe _____

Parent or guardian is responsible for providing the school with any medication, special food, equipment that the student may require during the day. Medication, Procedure Authorization, and Physical Education (PE) forms may be found at https://www.fcps.edu/registration/forms or obtained in the school Health Room.

Parental Consent: I agree to allow my child's healthcare provider(s) to discuss information contained in this form with FCPS staff and Public Health Nurse. ☐ Yes ☐ No

_____ _____
Healthcare Provider Name Healthcare Provider Phone

_____ _____ _____
Parent/Guardian Name (Print or Type) Parent/Guardian Signature Date

Public Health Nurse Use Only Below this Line

☐ HIF Reviewed ☐ Follow Protocol (SH Care Emerg.-Temp. Care Guidelines) ☐ Health Conditions List (Medical Flag) ☐ Action Plan/Health Plan or Procedure

Notes

_____ _____ _____
Public Health Nurse Name Public Health Nurse Signature Date