



HEALTH INFORMATION

TO BE COMPLETED BY PARENT/GUARDIAN EACH SCHOOL YEAR

FAIRFAX COUNTY HEALTH DEPARTMENT

PART 1: PARENT OR GUARDIAN TO COMPLETE. Parent/Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.

Student Name: Last	First	M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB: 	Grade:	School Year:
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Home Phone: ()	Father's Work Phone: ()	Mother's Work Phone: ()
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My child has a medical condition that may affect his/her school day: NO YES (please complete Part 2)

Parent or Guardian Name (Print or Type)

Parent or Guardian Signature Date

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Check with the school clinic to obtain correct medication and procedure forms.

ALLERGIES

Allergy Type:

- Food List food(s) _____
- Bee sting
- Other (list) _____

Reactions:

- Coughing Hives Rash
- Difficulty breathing Local swelling Wheezing
- Generalized swelling Nausea Other _____

Currently prescribed treatments to be used IN SCHOOL:

- Oral antihistamine (Benadryl, etc.) Epi-pen Other _____

ASTHMA

Triggers: Exercise Environmental Other (list) _____

Physical Education Restrictions: None Self limits Other _____

Symptoms or reactions:

- Chest tightness, discomfort, or pain Difficulty breathing Throat itch, tightness, or soreness
- Coughing Hoarseness Wheezing
- Other _____

Currently prescribed treatments to be used IN SCHOOL:

- Inhalers Oral antihistamines Oral steroids
- Nebulization Oral bronchodilator Peak flow monitoring

Date of last hospitalization related to Asthma _____

DIABETES

Currently prescribed treatments to be used IN SCHOOL:

- Insulin: Syringe Pen Pump
- Blood sugar testing
- Glucagon
- Oral medication(s) List medication(s) _____

Is special scheduling of lunch or Physical Education required? NO YES

SEIZURE DISORDER

Type of seizure:

- Absence (staring, unresponsive) Complex Partial Generalized Tonic-Clonic (Grand Mal/Convulsive)
- Other (explain) _____

Physical Education Restrictions: NO YES

Medications needed IN SCHOOL: NO YES List medication(s) _____

Date of last seizure _____ Length of seizure _____

OTHER HEALTH CONDITIONS

- Cancer Hemophilia Heart Condition Physical disability Other (explain) _____

Physical Education Restrictions: NO YES

Medication needed IN SCHOOL: NO YES List medication(s) _____

Special procedures (i.e.: catheterization, cardiac monitor, etc.) required IN SCHOOL: NO YES (explain): _____

VISION CONDITIONS

- Contacts/glasses
- Other _____

HEARING CONDITIONS

- Hearing aid(s)
- Other _____

PART 3: SCHOOL PUBLIC HEALTH NURSE TO COMPLETE if parent/guardian indicates medical condition(s).

- Health condition noted:
 - Follow protocol (SH Care Emergencies – Suggestion for Temporary Care Manual)
 - Medical Flag
 - IHCP/P

PHN Signature

Date

Notes: _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or of the eligible student.

RETURN COMPLETED FORM TO SCHOOL CLINIC AS SOON AS POSSIBLE