Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

# HEALTH INFORMATION

Complete this form every school year to inform us about your student's existing and new health conditions that affect your student's 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.

**Section A: Demographics:**

| Student Name: Last | First | Middle | Date of Birth |
|---|---|---|---|
| | | | |

| School Year | School Name | Grade | Teacher/Counselor | Gender: ☐ Male ☐ Female ☐ Non-Binary |
|---|---|---|---|---|
| | | | | |

| 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: Severe or Life-Threatening Health Conditions:**

| Condition | Check if Yes | Comment |
|---|---|---|
| **Severe Allergies/Anaphylaxis** | ☐ | ☐ Foods: _____<br>☐ Insect Sting: _____<br>☐ Latex<br>Epinephrine prescribed? ☐ Yes ☐ No<br>Epinephrine injection previously given? ☐ Yes ☐ No If yes, date of injection: _____ |
| **Asthma** | ☐ | Triggers: ☐ Exercise ☐ Environmental ☐ Upper Respiratory Infection ☐ Other: _____<br>Inhaler prescribed? ☐ Yes ☐ No Nebulizer Treatment prescribed? ☐ Yes ☐ No<br>Number of Emergency Room (ER) Visits in the last calendar year: ____ |
| **Diabetes** | ☐ | ☐ Type 1 ☐ Type 2 Diagnosis Date: _____ Name of emergency medication: _____<br>Glucose Monitoring: ☐ Glucometer ☐ CGM Insulin Administration: ☐ Syringe ☐ Pen ☐ Pump |
| **Seizures** | ☐ | Type of Seizure: _____ Date of last seizure: _____<br>Emergency Medication Needed at school? ☐ Yes ☐ No VNS implanted? ☐ Yes ☐ No |

**Section C: Current Physical Health Conditions:**

| Condition | Check if Yes | Comment (Please provide details) |
|---|---|---|
| Allergies (non-life threatening) | ☐ | |
| Blood Disorder | ☐ | |
| Cancer | ☐ | Currently Immunocompromised ☐ Yes ☐ No |
| Cystic Fibrosis | ☐ | |
| Dental/Oral Health Condition | ☐ | |
| Ear, Nose & Throat Conditions | ☐ | Please specify: |
| Endocrine Disorder (other than Diabetes) | ☐ | |
| Food Intolerance | ☐ | Foods: _____<br>Gastrointestinal/Digestive Distress ☐ Yes ☐ No |
| Food/Dietary Preference | ☐ | |
| Gastrointestinal/Stomach/Bowel | ☐ | |
| Hearing Conditions | ☐ | |
| Heart/Cardiovascular | ☐ | |
| Kidney/Urinary Tract Disorders | ☐ | |
| Headache/Migraines | ☐ | |
| Lung Disease (other than Asthma) | ☐ | |
| Mobility Impairment | ☐ | |

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

**Section D: Current Health Conditions, Continued:**

| Condition | Check if Yes | Comment (Please provide details) |
|---|---|---|
| Muscle/Bone/Joint/Arthritis | ☐ | Please specify: |
| Neurological (other than seizures) | ☐ | ☐ Brain Injury/Concussion/Date Diagnosed: _____ ☐ Cerebral Palsy ☐ Other: _____ |
| Skin Condition | ☐ | ☐ Eczema ☐ Other: _____ |
| Vision Conditions | ☐ | ☐ Contacts/Glasses ☐ Non-Correctable ☐ Other: _____ |
| Other Health Conditions | ☐ | ☐ Autism ☐ Down Syndrome ☐ Other: _____ |
| **Emotional/Mental Health Conditions:** | | |
| ADD/ADHD | ☐ | Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No |
| Anxiety | ☐ | Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No |
| Depression | ☐ | Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No |
| Eating Disorder | ☐ | Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No |
| Other: _____ | ☐ | Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No |

**Section E: Health Procedures:**

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

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

**Section F: List all medications and dosages your child receives on a regular basis and indicate which ones to be taken at school:**

_____

_____

_____

**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 School Public Health Nurse. ☐ Yes ☐ No

_____ Healthcare Provider Name

_____ Healthcare Provider Phone Number

_____ 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 Condition List

☐ Mental Health Condition List ☐ Action Plan/Health Plan or Procedure

Notes: _____

_____

_____

_____

_____

_____ Public Health Nurse Name

_____ Public Health Nurse Signature

_____ Date