



HEALTH INFORMATION

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SCHOOL YEAR

PART 1 Parent Or Guardian To Complete. Parent or guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.

Student's Name	Last	First	Middle	Sex	DOB
				<input type="checkbox"/> M <input type="checkbox"/> F	

School Year	Grade	Teacher's Name
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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 or her school day NO YES (please complete Part 2)

Parent's or Guardian's Name (Print or Type)

Parent's or Guardian's Signature

Date

PART 2 Complete All Boxes That Apply To Your Child. Parent or 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 procedural forms. If an individual school health care plan is indicated, parent or guardian is responsible for providing the school public health nurse with necessary medical information, appropriate authorization forms, and written consent to exchange information with the child's physician.

ALLERGIES

Allergy Type:

Food List food(s) _____

Medication List medicine(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.) EpiPen 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

Nebulizer 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 Heart condition (be specific) _____
- Hemophilia Physical disability (be specific) _____
- Respiratory (be specific) _____
- Other (explain) _____

Physical education restrictions NO YES

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

Special procedures (e.g. 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 or guardian indicates medical condition(s).

- Health condition noted
 - Follow protocol (school health care emergencies–suggestion for temporary care manual)
 - Medical flag
 - Individual health care plan or procedure

Public Health Nurse's 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, guardian, or the eligible student.