HEALTH INFORMATION

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SCHOOL YEAR

FAIRFAX COUNTY HEALTH DEPARTMENT

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 Name: Last	First	M.I.	Sex ❑ M ❑ F	DOB: | |	Grade:	School Year:

Home Phone: ( )	Father's Work Phone: ( )	Mother's Work Phone: ( )

My child has a medical condition that may affect his or 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 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 procedure forms.

❑ ALLERGIES

Allergy Type:

- ❑ Food List food(s) ______________________________
- ❑ Bee sting
- ❑ Other (list) ______________________________

Reactions:

- ❑ Coughing
- ❑ Difficulty breathing
- ❑ Generalized swelling
- ❑ Hives
- ❑ Local swelling
- ❑ Nausea
- ❑ Rash
- ❑ Wheezing
- ❑ 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
- ❑ Coughing
- ❑ Other ______________________
- ❑ Difficulty breathing
- ❑ Hoarseness
- ❑ Throat itch, tightness, or soreness
- ❑ Wheezing

Currently prescribed treatments to be used *IN SCHOOL*:

- ❑ Inhalers
- ❑ Nebulization
- ❑ Oral antihistamines
- ❑ Oral bronchodilator
- ❑ Oral steroids
- ❑ 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

CONTINUE ON REVERSE

❑ 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 (e.g.: catheterization, cardiac monitor, etc.) required *IN SCHOOL:* ❑ NO ❑ YES (explain):__________

____

❑ VISION CONDITIONS

❑ Contacts or 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/Procedure

______________________________________ 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