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 student'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.

Student Name: Last	**First**	**Middle**

School Year	**Grade**	**Gender:** ☐ Male ☐ Female	**Date of Birth:**	**New FCPS Enrollment:** ☐ Yes ☐ No

Parent/Legal Guardian Name: 1.	**Contact Number Home:** 1.	**Contact Number Cell:** 1.	**Contact Number Work:** 1.
Parent/Legal Guardian Name: 2.	**Contact Number Home:** 2.	**Contact Number Cell:** 2.	**Contact Number Work:** 2.

Allergies	**Yes**	**No**	For all allergies included	1. Name of allergies 2. Symptoms of reaction 3. Date of last reaction
Food				
Food Intolerance				
Latex				
Insect Sting				
Environmental				

For all health conditions checked **YES below,** in the **Comments** section:

1. Describe the health condition and any changes occurring over the past year, If **NO Change** indicate by checking that column
2. Provide the date of last Physician, Therapist, or other healthcare provider visit in the column under **Date of Last Provider Visit**

Health Conditions	**Yes**	**No**	**Comments**	No Change	Date of Last Provider Visit
ADD/ADHD					
Asthma			Date of last hospitalization/Emergency Room Visit		
Anxiety					
Breathing Problems					
Bladder/Kidney					
Blood Disorder					
Cancer					
Dental Problems					
Depression					
Diabetes			Date of last visit to Endocrinologist/Physician	Insulin	Other
Type 1				☐ Syringe ☐ Pen ☐ Pump	
Type 2					

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SHOW Instruction box

Health Conditions	YES	NO	Comments	NO Change	Date of Last Provider Visit (MM/YY)
Eating Disorders					
Headaches					
Hearing Impairment					
Heart					
Neurological					
Muscle/Bones/Joint					
Seizures			Type & Date of last seizure:		
Skin Condition					
Stomach/Bowels					
Visual Impairment			☐ Glasses ☐ Contacts		
Other Please identify:					

If your child needs **medication** in school, please complete the Medication Authorization with indicated physician signatures, found at https://www.fcps.edu/registration/forms

Does your child require any health procedures or need any special equipment during the school day?
https://www.fcps.edu/sites/default/files/media/forms/se180.pdf ☐ Yes ☐ No

If Yes, please describe _____

Does your child's health condition restrict participation in Physical Education (P.E.)? ☐ Yes ☐ No
If yes, please have your physician complete the Physical Education form (SS/SE-200) for participation in P.E.
https://www.fcps.edu/sites/default/files/media/forms/se200.pdf

Parental Consent: I agree to allow school and health department staff to discuss information contained in this form with my child's healthcare provider. _____ Primary Care Provider(s) _____ Phone Number(s)

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

Parent or guardian is responsible for providing the school with any medication, special food or equipment that the student may require during the day. Medication and Procedure Authorization forms are available at https://www.fcps.edu/registration/forms or obtained at the school health room.

School Public Health Nurse to Complete

☐ Health Information Form Reviewed

☐ Follow protocol (School Health Care Emergencies-Suggestion for Temporary Care)

☐ Medical flag ☐ Action plan or procedure

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

FAIRFAX COUNTY PUBLIC SCHOOLS

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor :	Bus # (AM):	Bus # (PM):

☐ Student has medical alert information on file. See page 2 for details. Student Cell _____

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the enrolling parent. The enrolling parent is the natural or adoptive parent or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Enrolling Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Resides with Language: E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: ☐ Resides with Language: E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: ☐ Resides with Language: E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: ☐ Resides with Language: E-mail:

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the school day.

Name of Person	Relationship	Language	Telephone

* Please remember to sign page 2.

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STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor:	Bus # (AM):	Bus # (PM):

Siblings attending the same school (complete if applicable).

Name(s): _____

Name(s): _____

Primary Internet access in the home for this student is

☐ Cellular ☐ Broadband ☐ Other ☐ None ☐ Declined

Do you have a device for this student to use that meets their educational needs? ☐ Yes ☐ No ☐ Declined

CURRENT HEALTH CONDITIONS

Below check any current health condition(s) that EMS or an emergency room physician should know about health of your student. **Also complete and submit Health Information form SS/SE-71 if your child has a health condition(s) that require(s) attention during the school day. See below for medical alert information currently on file.**

☐ allergies (be specific)
- ☐ foods _____
- ☐ medicines _____
- ☐ bee sting or insect bite _____
- ☐ other _____

☐ asthma

☐ cancer

☐ diabetes

☐ hearing problems ☐ hearing aid(s)

☐ heart problems (be specific) _____

_____

☐ hemophilia ☐ sickle cell anemia

☐ physical disability (be specific)

_____

☐ respiratory (be specific)

_____

☐ seizures

☐ vision problems (be specific) _____

☐ glasses ☐ contacts

☐ other (be specific)

_____

_____

List all medications and dosages your child receives on a continual basis:

_____

_____

_____

MEDICAL ALERT INFORMATION ON FILE

This space reserved for system printing of Health Information

PHYSICIAN INFORMATION

My child's medical care is provided by: _____ (name of doctor, clinic, or HMO) _____ (telephone)

Does your child have health insurance? ☐ Yes ☐ No

If yes, medical coverage is provided by: _____ (health insurance company, assistance program, HMO, etc.) _____ (telephone)

First aid and emergency treatment will be provided to students in accordance with the current version of FCPS Regulation 2102 or in accordance with the student's individualized health plan.

ENROLLING PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____