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 education record and is securely stored in the health room. De-identified, aggregate health data is also used by Fairfax County Public Schools (FCPS) and the Fairfax County Health Department (FCHD) to complete required public health reporting to the Virginia Department of Education and to monitor health needs in the school community. 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: _____ ☐ Insect Sting: _____ ☐ Latex Epinephrine prescribed? ☐ Yes ☐ No Epinephrine injection previously given? ☐ Yes ☐ No If yes, date of injection: _____
Asthma	☐	Triggers: ☐ Exercise ☐ Environmental ☐ Upper Respiratory Infection ☐ Other: _____ Inhaler prescribed? ☐ Yes ☐ No Nebulizer Treatment prescribed? ☐ Yes ☐ No Number of Emergency Room (ER) Visits in the last calendar year: ____
Diabetes	☐	☐ Type 1 ☐ Type 2 Diagnosis Date: _____ Name of emergency medication: _____ Glucose Monitoring: ☐ Glucometer ☐ CGM Insulin Administration: ☐ Syringe ☐ Pen ☐ Pump
Seizures	☐	Type of Seizure: _____ Date of last seizure: _____ 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)
Height/Weight		Height: ____ ft. ____ in. Weight: _____ lbs.
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: _____ 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:

The Fairfax County Health Department provides referral information to community medical resources providing free physical examinations. Visit https://www.fairfaxcounty.gov/health/clinics.

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