Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

FAIRFAX COUNTY PUBLIC SCHOOLS

HEALTH INFORMATION

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SCHOOL YEAR

SHOW Instruction box

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	Middle	Sex ☐ M ☐ F	DOB

School Year	Grade	Teacher Name

Home Phone	Father Work Phone	Mother 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 health room 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 Type ☐ Mild ☐ Severe Date of last severe reaction _____

☐ Coughing ☐ Hives ☐ Rash

☐ Difficulty breathing ☐ Local swelling ☐ Wheezing

☐ Generalized swelling ☐ Nausea ☐ Other _____

Currently prescribed medications and treatments

☐ Oral antihistamine (Benadryl, etc.) ☐ Epinephrine ☐ Other _____

☐ FOOD INTOLERANCE

☐ Due to Gastrointestinal (Digestive) distress List Foods _____

☐ Due to Religious preferences List Foods _____

☐ ASTHMA

Triggers ☐ Exercise ☐ Environmental ☐ Other (list) _____

Symptoms

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Throat itch, tightness, or soreness

☐ Coughing ☐ Hoarseness ☐ Wheezing

☐ Other _____

Currently prescribed medications and treatments

☐ Inhalers ☐ Oral antihistamines ☐ Oral steroids

☐ Nebulizer ☐ Oral bronchodilator ☐ Peak flow monitoring

Date of last hospitalization related to asthma _____

CONTINUE ON REVERSE