# FCPS ANNUAL HEALTH HISTORY UPDATE

Student's Name _____ Date of Birth _____ Grade _____
Mother/Guardian_____ Cell Phone _____ Work Phone_____
Father/Guardian_____ Cell Phone _____ Work Phone_____
Emergency Contact_____ Cell Phone _____ Work Phone_____
Physician _____ Phone _____

☐New to FCPS. If yes, last school attended: _____ State: _____

☐**Current 504 plan** ☐**Current IEP**

Does your child take any medication on a routine basis?
Name of medication: _____ Purpose: _____ Takes at home☐ Takes at school☐
Name of medication: _____ Purpose: _____ Takes at home☐ Takes at school☐
Name of medication: _____ Purpose: _____ Takes at home☐ Takes at school☐

***Please contact the school nurse if your child must take any prescription or over the counter medications at school.***

| NO | YES | CONDITION | COMMENTS |
|---|---|---|---|
| | | **ADD/ADHD** | |
| | | **ALLERGIES**<br>☐ EpiPen at home<br>☐ EpiPen at school | ☐ Bees/Insect allergy<br>☐ Lactose Intolerance<br>☐ Food Allergy:_____<br>☐ Medication Allergy_____<br>☐ Other_____ |
| | | **ASTHMA** | Rescue inhaler: ☐ at home ☐ at school in clinic ☐ at school with student<br>Nebulizer: ☐ at home ☐ at school in clinic<br>***Current Asthma Care Plan must be on file every school year if medications are needed at school.** |
| | | **BLADDER/BOWEL PROBLEMS** | Please explain: |
| | | **DIABETES** | ☐TYPE 1 ☐TYPE 2<br>***Students with diabetes must have a current Diabetes Care Plan on file at school every year.** |
| | | **HEART PROBLEMS** | Please explain: |
| | | **PHYSICAL LIMITIATIONS** | ☐Special equipment needed at school. Please list: |
| | | **SEIZURES** | ☐As an infant.<br>☐Currently on seizure medications at home.<br>☐Requires emergency seizure medication at school. |
| | | **SPEECH PROBLEMS** | Please explain: |
| | | **VISION/HEARING PROBLEMS** | ☐Glasses ☐Contacts ☐Hearing aid |
| | | **OTHER** | |

**Parent/Guardian Signature_____Date_____**