Fulton County Schools
Where Students Come First

Reportable and Potential Reportable Communicable Disease Form

Student Health Services

☐ Student ☐ Staff Date: _____

Name: _____ School: _____

Grade *(students only)*: _____ Date of Birth *(students only)*: _____

Address: _____

Parent/Guardian Name *(student's)*: _____

Parent/Guardian Contact Number *(student's)*: _____

Onset Date of *(check one)* ☐ Illness ☐ Hospitalization _____

Diagnosis/Potential Illness: _____ Confirmed Diagnosis: ☐ Yes ☐ No

Symptoms: _____

Medical Facility That Provided Treatment *(if applicable)* _____

Facility Phone Number: _____

Physician's Name: _____

Fulton County Department of Health & Wellness Contact: _____

Fulton County Department of Health & Wellness Telephone Number: _____

Follow-up Information: _____

_____

_____

_____

Letter(s) sent from school to parent/guardian: ☐ Yes ☐ No *{Attach copy of letter(s) to this form}*

Form Completed By: *(Name & Title)*: _____

(This section to be completed by Student Health Services staff ONLY)

CONFIRMED DIAGNOSIS: _____ _____

SHS STAFF SIGNATURE DATE

Revised 7/08