FELL CHARTER SCHOOL
School Health Services
Health Data Form 2021-2022

Information provided on this form will enable school personnel to deal most effectively with your child's health considerations and allow him/her to receive the maximum benefits from his/her educational experience. Attach additional paperwork if necessary.

Student's Name _____ Grade _____ DOB _____ M / F

Father's Name _____ Mother's Name _____

Guardian (if other than parent) _____

Student's Physician _____ Contact Number _____

Student's Dentist _____ Contact Number _____

Does your child take medication on a daily basis? Yes / No
Medication _____ Reason _____
Will he/she need to take the medication during school hours? Yes / No

Has your child ever had an allergic reaction to any medication? Yes / No
Name of medication _____ Reaction _____
Treatment in case of exposure
_____

Is your child allergic to specific foods or other substances? Yes / No
Food/Substance _____ Reaction _____
Treatment in case of exposure
_____

Has your child ever had an allergic reaction to Bee/Wasp stings? Yes / No
Medication _____ Reaction _____
Treatment in case of exposure
_____

Does your child have any other health problems? Yes / No
Condition(s)
_____
Condition(s)
_____

Has your child been hospitalized for surgery, serious illness, or accident? Yes / No
Comments
_____

Does your child have difficulty with Vision? Yes / No
Does your child have difficulty with Hearing? Yes / No
Does your child have difficulty with Speech? Yes / No

Is there anything more about your child's health that you believe is important for the school to know?
Yes / No

May this information be shared with other school personnel, as necessary for the health of your child?
Yes / No

Signature of Parent/Guardian _____ Date _____