FELL CHARTER SCHOOL

School Health Services

Health Information Form (2024-2025)

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.

Student's Name: ________________________ Grade: ____ DOB: _______ M/F

Father's Name: __________________ Mother's Name: ____________________
Guardian (if other than parent): _________________________

Student's Physician: __________________ Student's Dentist: ___________________

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: _______________________________________

Has your child ever had an allergic reaction to Bee/Wasp stings? Yes/No
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: ______________________________________

Does your child have any health problems? Yes/No
Condition(s):____
Comments: ____

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 think 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: _________

Reviewed by Nurse ____Date:__________