

**FELL CHARTER SCHOOL**  
*School Health Services*

**Health Information Form (2025-2026)**

*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. Must be filled out each year.*

**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:** \_\_\_\_\_