

FELL CHARTER SCHOOL
School Health Services

Health Information Form (2026-27)

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:** _____