Oak Hill Academy
347 Midd.-Lincroft Rd.
Lincroft, NJ
07738

(732) 530-1343

Medical Information Form

Student_____ Date of Birth_____
Parents_____
Address_____
Home Phone_____ Cell Phone_____
Date of Entry_____ Grade _____ M or F _____

Previous School _____
Address_____
Phone Number _____

Family History

This child is # _____ of _____ children.
Any recent family changes in family life_____
_____
Lives with both parents_____ shared custody_____ single parent_____
List any custody issues or visitation limitations that we need to know with proper documentation _____
_____

Habits and Personality

Please describe this child in terms of temperament and attitudes
_____
List any specific information about your child you would like the school to know: _____

Parent Signature_____

Student _____

Student Medical History

Please check if medical diagnosis applies to your child:

ALLERGIES_____	**Diabetes_____**
EpiPen _____	**Heart Disease_____**
Drug Allergies_____	**Operations_____**
Asthma_____	**Injuries_____**
Uses Inhaler_____	**Seizures_____**
Vision – glasses/contacts_____	**Other_____**
Hearing difficulty_____	**_____**

Medications child is taking _____
(All medications need a doctor's order to be given at school)

In accordance with the Privacy Act please sign below:

"Health Information will be shared with School Personnel on a "Need to Know" basis.

_____ _____
Signature of Parent Date