



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 _____

Family History

This child is # _____ of _____ children.
Any recent family changes to be noted in family life _____

Lives with both parents _____ shared custody _____ single parent _____
List any custody issues or visitation limitations that we need to be aware of with proper documentation _____

Habits and Personality

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

Parent Signature _____

Student Medical History

Please check if medical diagnosis applies to your child:

ALLERGIES _____

EpiPen/Auvi-Q _____

Drug Allergies _____

Asthma _____

Uses Inhaler _____

Vision – glasses/contacts _____

Hearing difficulty _____

Diabetes _____

Heart Disease _____

Operations _____

Injuries _____

Seizures _____

Other _____

Medications 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