OAK HILL ACADEMY

• SINCE 1981 •

Student / Medical Information Form

Student_____ **Date of Birth**_____
Parents_____
Address_____
Home Phone_____ **Cell Phone**_____
Date of Entry_____ **Grade** _____ **Age** ___ **M or F** ____

Previous School _____
Address_____
Phone Number_____

Family History

This child is # _____ of _____ children.
Any recent 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 your child in terms of temperament and attitudes
_____
List any specific information about your child you would like the school to know: _____

Parent Signature_____

Medical History Form

Student _____

Please check if Medical Diagnosis applies to your child:

FOOD ALLERGIES_____
EpiPen or Auvi-Q_____

Drug Allergies_____	**Operations_____**
Asthma_____	**Injuries_____**
Uses Inhaler_____	**Seizures_____**
Vision – glasses/contacts_____	**Heart Disease_____**
Hearing difficulty_____	**Other _____**

Medication child is taking at home
Please list_____
_____
_____

Over the Counter medications or Prescription medications need a doctor's order to be given at school if needed

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