



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** \_\_\_\_\_

**EpiPen** \_\_\_\_\_

**Drug Allergies** \_\_\_\_\_

**Asthma** \_\_\_\_\_

**Uses Inhaler** \_\_\_\_\_

**Vision – glasses/contacts** \_\_\_\_\_

**Hearing difficulty** \_\_\_\_\_

**Diabetes** \_\_\_\_\_

**Heart Disease** \_\_\_\_\_

**Operations** \_\_\_\_\_

**Injuries** \_\_\_\_\_

**Seizures** \_\_\_\_\_

**Other** \_\_\_\_\_

**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**