Oak Hill Academy
Medical Authorization Form

Name of Child_____ Birthdate_____

Child's Social Security Number_____

Name of Parent(s) or Guardian_____

Home Address_____

City, State, Zip_____ Phone_____

Place of Mother's Employment_____ Phone_____

Address_____

Place of Father's Employment_____ Phone_____

Address_____

The parent(s)/guardian authorizes Oak Hill Academy to obtain immediate medical or dental care and consents to the hospitalization of, the performance of necessary diagnostic tests upon the use of surgery, and/or the administration of drugs to his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers routine medical care and those situations which are emergencies when the parent cannot be reached. Otherwise, he/she expects to be notified immediately.

Signature of Parent/Guardian_____

Information, if available:

Physician_____ Phone_____

Address_____

Dentist_____Phone_____

Address_____

PAYMENT FOR MEDICAL TREATMENT FOR THIS CHILD WILL BE MADE BY

Guarantor Name: _____
Phone number: _____
Mailing address: _____
_____

Insurance Co. Name_____

A copy of the student's insurance card MUST be submitted with this form. Please attach a copy of the front and back of the insurance card. If there is a separate card for prescription coverage, please include that as well.

THE TURNING POINT

THE TURNING POINT

OAK HILL ACADEMY
SCHOOL PHYSICAL FORM

Name of Child: _____
Last First Middle

Preferred name: _____ Date of Birth: _____ Date of Exam: _____

Sex: M____F_____ Height:_____ Weight: _____ Temp:_____ BP:_____/_____

Vision: Corrected: Right 20/__
Left 20/__
Uncorrected: Right 20/__
Left 20/__

Hearing: (Gross): Right ____Left___
15 ft. Right____Left___

Urinalysis: Sugar: _____ Albumin: _____
Micro: _____

Hgb or Hct (if indicated) _____
Date: _____ Results: _____
Recommendations: _____
_____
_____

Abnormalities: (indicate any abnormal findings)

System	Description (Attach additional sheets if necessary)
Head, ears, nose, throat	
Eyes	
Respiratory	
Cardiovascular	
Gastrointestinal	
Hernia	
Genitourinary	
Musculoskeletal	
Metabolic/Endocrine	
Neuropsychiatric	
Skin	
Mammary	

Medical History:

Diagnosis:	Date of Diagnosis:	Treatment (if required):

(over)

Please list any past hospitalizations, date, and brief explanation:

_____

_____

_____

_____

_____

Tuberculin (PPD) test (if indicated)

Date administered: _____ Date Read: _____ Results: _____mm induration

Read By (signature of medical professional): _____

(Chest x-ray must be done if positive PPD.)

_____ _____

Signature of clinician/or stamp required **Date**

_____ _____

Print name of physician/physician assistant/ Nurse Practitioner **Office Telephone**

Office Address:

_____

Immunization Record:

Oak Hill Academy requires compliance with immunization schedule recommended and published by the Virginia Department of Health (available at http://www.vdh.virginia.gov/Epidemiology/Immunization/acip.htm).

A copy of the student's immunization record MUST be attached to the school physical form.

If the student has a religious or medical exemption, the appropriate form must accompany this physical in lieu of vaccination records (available at http://www.vdh.virginia.gov/content/uploads/sites/11/2016/04/cre_1.pdf)

Activities alert: It is understood by the undersigned parent/guardian that their enrolled child has permission to take part in all physical and sports related activities now or in the future, and that some of these activities may be rigorous and physically demanding. These activities are supervised and appropriate instruction is incorporated into each activity. If there are any impairments that the parent or guardian is aware of that might limit or prohibit their child from participating in these activities, they should be listed below. Specific limits should also be recommended by the parent or physician below. If no impairments are listed, then it is assumed and agreed upon by the parent/guardian that their child will participate in physical/sports activities.

_____

_____

_____

_____

_____ **Signature of Parent/Guardian**

_____**Date**

THE TURNING POINT

Oak Hill Academy
Over-The-Counter (OTC) Medication
Authorization Form

Student Name: _____
Date of Birth: _____

Medication Allergies: No____ Yes____

If yes, give name of medication(s): _____

Describe reaction:

_____

_____

With parental consent, a variety of OTC medications are available for your child when needed. These medications will be administered by Oak Hill nursing staff or other trained faculty/staff members. These include, but are not limited to: ibuprofen, acetaminophen, decongestant, cough medication, Benadryl, Zyrtec, topical creams, Pepto Bismol, etc.

Please list any specific medications you DO NOT want your child to receive:

_____

_____

_____

I, _____, give Oak Hill Academy permission to administer Over-the-Counter Medications to my child when necessary.

_____
Date

THE TURNING POINT

Oak Hill Academy
Authorization/Parental Consent for Administering Medication
(Use a separate authorization form for each medication.)

STUDENT'S LAST NAME _____ , **FIRST NAME** _____, **M.I.** ____
GRADE _____ **DATE OF BIRTH** _____/_____/_____

Allergies _____

Parental Consent
As the parent or guardian of _____, I give my permission for him/her to take the following prescribed medication while attending Oak Hill Academy.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date

Asthmatic/Diabetic ONLY
This student is both capable and responsible for self-administering this medication:
_____ NO _____ YES - Supervised _____ YES - Unsupervised
This student may carry this medication: _____ NO _____ YES

MEDICATION AUTHORIZATION

Relevant Diagnosis _____
Medication _____
Dates medication must be administered at school:
____ Short Term (List dates to be given _____)
____ Every day at school ____ Episodic/Emergency Events ONLY
Dosage (Amount) _____ Route _____ Form _____
Time(s) of Day _____
A. Serious reactions can occur if the medication is not given as prescribed: __ YES __ NO
If yes, describe:
B. Serious reactions/adverse side effects from this medication may occur: __ YES __ NO
If yes, describe:
Action/Treatment for reactions: _____
Report to you: ____ YES ____ NO (Drug information sheet may be attached.)
Special Handling Instructions: ___ Refrigeration ___ Keep out of sunlight ___ Other
_____
Licensed Prescriber's Name _____
Telephone Number _____ Emergency Number _____

Prescription medications must be submitted to the Nurse's Office in original packaging that includes medication information and administration instructions.

(over)

MEDICATION AUTHORIZATION

Relevant Diagnosis _____
Medication _____
Dates medication must be administered at school:
____ Short Term (List dates to be given _____)
____ Every day at school ____ Episodic/Emergency Events ONLY
Dosage (Amount) _____ Route _____ Form _____
Time(s) of Day _____
A. Serious reactions can occur if the medication is not given as prescribed: __ YES __ NO
If yes, describe:
B. Serious reactions/adverse side effects from this medication may occur: __ YES __ NO
If yes, describe:
Action/Treatment for reactions: _____
Report to you: ____ YES ____ NO (Drug information sheet may be attached.)
Special Handling Instructions: ___ Refrigeration ___ Keep out of sunlight ___ Other
_____
Licensed Prescriber's Name _____
Telephone Number _____ Emergency Number _____

Prescription medications must be submitted to the Nurse's Office in original packaging that includes medication information and administration instructions.

MEDICATION AUTHORIZATION

Relevant Diagnosis _____
Medication _____
Dates medication must be administered at school:
____ Short Term (List dates to be given _____)
____ Every day at school ____ Episodic/Emergency Events ONLY
Dosage (Amount) _____ Route _____ Form _____
Time(s) of Day _____
A. Serious reactions can occur if the medication is not given as prescribed: __ YES __ NO
If yes, describe:
B. Serious reactions/adverse side effects from this medication may occur: __ YES __ NO
If yes, describe:
Action/Treatment for reactions: _____
Report to you: ____ YES ____ NO (Drug information sheet may be attached.)
Special Handling Instructions: ___ Refrigeration ___ Keep out of sunlight ___ Other
_____
Licensed Prescriber's Name _____
Telephone Number _____ Emergency Number _____

Prescription medications must be submitted to the Nurse's Office in original packaging that includes medication information and administration instructions.

Please attach additional information as needed.