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 Company Name:_____
Primary Subscriber's Name (Person who owns/has the insurance policy):_____
Primary Subscriber's Date of Birth:_____

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.

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:_____/_____ HR_____

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	
Psychiatric	

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics:

☐Medically Eligible for ALL Sports Without Restriction

☐Medically Eligible for ALL sports without restriction with recommendation for further evaluation or treatment of:_____

☐Medically Eligible ONLY for the following sports: _____
Reason:_____

☐NOT Medically Eligible pending further evaluation of:_____

☐NOT Medically Eligible for ANY Sports.

(over)

Medical History:

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

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 https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf**).**

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**

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** _____/_____/_____

MEDICATION

Medication Name _____

Dosage (Amount) _____ Route _____ Form _____ Time(s) of Day _____

Relevant Diagnosis (why medication is prescribed)_____

Frequency of medication administered at school:
____ Every day at school ____ Episodic/Emergency Events ONLY
____ Short Term (List dates to be given _____)

- Serious effects can occur if the medication is not given as prescribed: __ YES __ NO

If yes, describe:_____

- Serious reactions/adverse side effects student has from taking this medication: __ YES __ NO

If yes, describe:_____

*Action/Treatment for reactions/adverse side effects: _____
*Report to you: ____ YES ____ NO

Special Handling Instructions: ___ Refrigeration ___ Keep out of sunlight ___ Other (describe)_____

Licensed Prescriber's Name _____
Provider's Number _____

****If the medication listed in this box is related to Asthma/Diabetes/Anaphylaxis Medication ONLY****

A. This student is both capable and responsible for self-administering this medication:
_____ NO _____ YES - Supervised _____ YES - Unsupervised
B. This student may carry this medication: _____ NO _____ YES (*If no, then access will be maintained with a supervising adult)

Prescription medications must be submitted to the Nurse's Office in original packaging that includes medication information and administration instructions. If medication is administered via injection, the solution bottles must be labeled and in original packaging from manufacturer

Attach Additional Sheets as needed

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** _____/_____/_____

List All Student 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

MEDICATION

Medication Name _____

Dosage (Amount) _____ Route _____ Form _____ Time(s) of Day _____

Relevant Diagnosis (why medication is prescribed)_____

Frequency of medication administered at school:
____ Every day at school ____ Episodic/Emergency Events ONLY
____ Short Term (List dates to be given _____)

- Serious effects can occur if the medication is not given as prescribed: __ YES __ NO
  If yes, describe:_____

- Serious reactions/adverse side effects student has from taking this medication: __ YES __ NO
  If yes, describe:_____

  *Action/Treatment for reactions/adverse side effects: _____
  *Report to you: ____ YES ____ NO

Special Handling Instructions: ___ Refrigeration ___ Keep out of sunlight ___ Other (describe)_____

Licensed Prescriber's Name _____
Provider's Number _____

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STUDENT HEALTH INFORMATION 2025-2026

(Parent/Guardian to complete)

AN IMPORTANT MESSAGE REGARDING YOUR CHILD'S HEALTH

The nurse works to promote good health among students and staff. Our goal is to help your child have a healthy, successful school year. The school nurse has guidelines to follow for the care of students on campus. Medications will be given according to the doctor's written directions with parent/guardian permission. The nurse has a supply of over-the-counter medications such as Tylenol, ointments, etc. to give to students, given parent/guardian signed permission. Students with life threatening allergies (Insect stings, Food Allergies, etc.) will need their physician to provide a written authorization for injectable medicine (epi-pen) to be stored at school. However, should a student have a sudden, undiagnosed, serious life-threatening reaction (anaphylaxis), 911 and the parent/guardian listed below will be notified. Trained personnel will administer an initial injectable dose of epinephrine. **If your child has a health condition, please contact the school nurse to set up a plan of care to meet your child's needs.**

Child's Name		Grade	Date of Birth	
Mother's Name	**Best Contact Phone Number**	**Email Address**		**Lives w/**
				☐
Father's Name	**Best Contact Phone Number**	**Email Address**		
				☐

Physician/Primary Care Provider	Office Phone Number
Dentist	**Office Phone Number**
Specialist	**Office Phone Number**

I give my permission to the school nurse to share or receive health-related information needed to care for my child with the providers listed above during the school year.	YES ☐	NO ☐

Please list any dietary restrictions:

If you have any changes to any of the above phone numbers or contact's for your child, please notify the school promptly.

_____ / _____

Parent/Guardian signature / Date

****Please Complete Both Sides Before Returning****

2025-2026 STUDENT HEALTH INFORMATION

(Parent/Guardian to complete)

Please check items below that pertain to your child's health and answer the related questions. This information will be in the health room (school nurse) and will be shared with faculty if necessary to best serve your child at school.

Student Name:	**Grade:**	**Date of Birth:**

Condition	Treatment	Description for school nurse
Diet: Regular □, Vegetarian □, Vegan □, Gluten Free □	Specific Considerations:	If this is allergy specific, please also list as allergy on form
Allergies: Medication □ Seasonal □ Food □ Environmental □ Other □	Has the allergy been diagnosed by a physician? □ Has your child every had to use an Epi-Pen? □ Has your child ever had an anaphylactic reaction? □	Allergic to what? _____ Type of reaction: _____ Date of Epi-Pen use: _____
Autism □		
Cancer: □ Type:	□ Undergoing treatment	□ In remission
Diabetes: Type I or II	Pills □ | Insulin: Pump □ Injection □	
Known Genetic Variations present		Type:
Head		
Epilepsy □ Seizures: Febrile □ Other: □	Medication_____ Diastat- Yes □ No □ | Valtaco - Yes □ No □	Date of last seizure: _____
Head Injury □ | Concussion □		Date of Injury/concussion: _____
Headache/Migraines □	Medication: Yes □ No □	Frequency_____
Psychological Disorder □ Type_____ ADD/ADHD □	Medication: Yes □ No □	Therapist Yes □ No □ Name:_____
Dermatology		
Skin problems: Eczema, abnormal skin pigmentations (café-au-lait, hemangiomas, mongolian spots, etc.) □		
Vision/Hearing		
Hearing Problems □		Hearing Aid Worn: Left □ Right □ Cochlear Implant: Yes □ No □
Vision Problems □	Wears: Glasses □ Contacts □ Reading Only □ ALL school work □	Date of last eye exam: _____
Circulatory/Respiratory		
Asthma □	Medication: Yes □ No □ Medication Name:_____	Date of last episode: _____ Know Triggers: _____
Cystic Fibrosis □	Enzymes: _____	Medication treatment: _____
Heart Condition/High Blood Pressure □		Specialist: _____
Blood Disorders: □ Hemophilia □ Nosebleeds □ Sickle Cell □ Other_____		Nosebleed Frequency: _____
Abdominal		
Kidney/Bladder Problems □		Specify: _____
Menstrual Problems □		Specify: _____
Stomach Problems □		
Musculoskeletal		
Arthritis □		
Cerebral Palsy □		
Multiple Sclerosis □		
Muscular Dystrophy □		
Orthopedic Problems □		Walking Aid/Braces: Yes □ No □
Spina Bifida □		

★ **Will your child need to take medication while attending OHA? □ Yes □ No (includes Inhaler, Epi-Pen, Diastat & Glucagon)**

If **YES,** please fill out the Administering Medication form, listing each medication/vitamin/etc. the student needs and sign the form.

No medications will be administered without written parental consent.

□ My child has NO health problems. _____Initials

****Please Complete Both Sides Before Returning****

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

Student Name: _____ Date of Birth: _____

Does the student have an allergy to any medication(s): No____ Yes____

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

_____

_____

_____

*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, the ones listed below (generic or name brand):

Pain / Fever Reducing Medications: Acetaminophen, ibuprofen, menstrual cramp relief.
Multiple Symptom Colds: Dayquil, Nyquil
Congestion / Allergies: Mucinex, Cetirizine, Pseudoephedrine, Loratadine, Benadryl
Minor Burns: Aloe, first aid & burn cream (lidocaine & benzalkonium), Derma Plast spray
Cough / Sore Throat: Robitussin, throat lozenges
Minor Cuts / Scrapes: Triple antibiotic ointment, petroleum jelly
Gastrointestinal Symptoms: Pepto Bismol, Imodium, Antacid Tablets, Simethicone, Colace, Meclizine, omeprazole
Itching: hydrocortisone cream, Benadryl cream
Eye Care: Natural Tears, dry eye relief, contact lens solution

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.

Signature:_____Date:_____