Greetings from the Hill! OAK HILL ACADEMY OHA Nurse Newsletter

💬 Welcome from the Health Office

Dear Parents & Guardians,

We're thrilled to welcome your child to Oak Hill Academy! Boarding school is an exciting journey filled with learning, growth, and new friendships. To help ensure a smooth and stress-free transition, we've prepared this simple checklist. By completing these steps before arrival, you'll help your student start the year healthy, prepared, and ready to thrive.

Warmly,

Crystal Reeves, MSN, RN, NCSN
School Nurse, OHA

💡 Nurse's Note

A little preparation goes a long way — the smoother the start, the happier and healthier your child's school year will be!

📞 Contact Information
Phone: (276) 579-2619
Email: nurse@oak-hill.net
Clinic Hours: Mon–Fri, 8:00 AM – 4:00 PM

✅ Medication Management 💊

- ☐ Send a 90-day supply of stable, routine medications (if available) in original pharmacy-labeled containers.
- ☐ Arrange refills with your pharmacy to be sent to school or brought during visits.
- ☐ For any short-term prescription needs, set up a parent account with Food City Pharmacy (276-773-2211) or Jefferson Drug (336-246-9492) (*Trip charges applied*)
- ☐ Once you arrive on campus, turn in all prescriptions, over-the-counter medications, vitamins, and supplements to the nurse's office.

✅ Paperwork & Health Forms 📋

- ☐ Fill out, sign, and return all health, consent, and emergency contact forms before arrival.
- ☐ Provide an up-to-date immunization record.
- ☐ Submit special care plans (asthma, allergies, diabetes, etc.) and any necessary supplies.

✅ Health & Wellness Prep ❤️

- ☐ Schedule a physical exam before school starts.
- ☐ Complete dental and vision check-ups.
- ☐ Encourage healthy habits — regular sleep, balanced meals, and hydration.

✅ Emotional Readiness 🙂

- ☐ Talk with your child about what to expect at boarding school.
- ☐ Teach self-advocacy skills for asking for help when needed.
- ☐ Pack comfort items from home to ease the transition.

✅ Communication 📞

- ☐ Save the nurse's phone number and email in your contacts.
- ☐ Watch for health office updates via email or newsletter.

Oak Hill Academy

Medical Authorization Form

Student Information

Name: _____ Date Of Birth (Month/Day/Year): _____ SSN: _____

Parent/Legal Guardian Information

Guardian 1

Name: _____ DOB (M/D/Y): _____

Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Guardian 2

Name: _____ DOB (M/D/Y): _____

Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Medical Providers (if available)

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Insurance Information

Insurance Company: _____

Policy #: _____ Group #: _____

Phone: _____

Mailing Address: _____

Primary Subscriber: _____ DOB: _____

Attach copies of the front and back of insurance card*

Authorization for Medical Treatment

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: _____ Date: _____

Printed Name: _____

Oak Hill Academy
Student Medical History Form

Student Information
Name: _____ DOB: _____

Allergies ***(include food, medication, environmental, insect, etc.) *Attach additional sheet if necessary****
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
☐ No known allergies

Current Medications ***(include prescriptions, OTC, vitamins, supplements) *Attach additional sheet if necessary****
Medication: _____ Dose/Frequency: _____
Medication: _____ Dose/Frequency: _____
Medication: _____ Dose/Frequency: _____
☐ No current medications

Current Medical Conditions
(e.g., asthma, diabetes, anxiety, ADHD, seizures, etc.)

☐ None

Past Medical History
Surgeries / Hospitalizations (with dates if known):

☐ None
Other Relevant Medical Conditions or Injuries:

☐ None

Dietary Restrictions / Special Needs
(e.g., lactose intolerance, gluten-free, religious restrictions, etc.)

☐ None

Additional Information for Medical Providers
(Anything else we should know to safely care for your student)

Emergency Considerations
Does your student carry or require:
☐ Inhaler ☐ EpiPen/Neffy ☐ Insulin ☐ Other: _____

Parent/Guardian Acknowledgment
I certify that the above information is accurate and complete to the best of my knowledge and understand that it is my responsibility to update the school with any changes.
Parent/Guardian Signature: _____ Printed Name: _____ Date: _____
Best Contact Phone: _____

OAK HILL ACADEMY
SCHOOL PHYSICAL FORM

Student Information

Name: _____ (Last, First, Middle) Sex: ☐ M ☐ F

Preferred Name: _____ DOB: _____ Exam Date: _____

Height	Weight	Temp	BP	HR	Vision (Corr)	Vision (Uncorr)	Hearing	Urinalysis	Hgb / Hct
___	___	___	___/___	___	R: 20/___ L: 20/___	R: 20/___ L: 20/___	Gross R: ___ L: ___ 15ft R: ___ L: ___	Glucose: ___ Albumin: ___ Micro: ___	Date: ___ Result: ___

Tuberculin (PPD) Test (if indicated)

Date: _____ Read: _____ Result: _____ mm By: _____

Recommendations (if indicated):

_____

Physical Examination – Abnormal Findings (if any)

System	Description
Head / Ears / Nose / Throat	_____
Eyes	_____
Respiratory	_____
Cardiovascular	_____
Gastrointestinal	_____
Hernia	_____
Genitourinary	_____
Musculoskeletal	_____
Metabolic / Endocrine	_____
Neuropsychiatric	_____
Skin	_____
Mammary	_____
Psychiatric	_____

Athletic Participation Recommendation

☐ Cleared for ALL sports without restriction

☐ Cleared for ALL sports with recommendation for further evaluation/treatment: _____

☐ Cleared ONLY for: _____ Reason: _____

☐ NOT cleared pending evaluation of: _____

☐ NOT cleared for ANY sports

_____

OAK HILL ACADEMY
SCHOOL PHYSICAL FORM

Current Diagnosis / Treatment

Diagnosis	Date	Treatment

Medical History (surgeries, injuries, etc)

_____

_____

Current Medications / Vitamins / Supplements: (Attach additional sheet as necessary)

Name	Dose	Route	Frequency	Time

Clinician Information

Clinician Signature: _____ Date: _____

Clinician Print Name: _____ Phone: _____

Office Address: _____

Immunization Record ***Record must be attached***

Must follow VA Dept. of Health schedule (**available at** https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf).

Exemptions require official form (**available at** http://www.vdh.virginia.gov/content/uploads/sites/11/2016/04/cre_1.pdf).

Attention Parents/Guardians

Activities Alert:

Student may participate in all physical/sports activities, including rigorous activity, under supervision with instruction provided.

List any impairments or restrictions (or none implies full participation): _____

_____

_____

Signature of Parent/Guardian: _____ Date: _____

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

Student Name: _____ Date of Birth: _____

Does the student have any allergies: No____ Yes____

If yes, list all allergies and their reactions: _____

_____

_____

_____

_____

If yes, does the student have an epi pen? No____ Yes_____

*With parental consent, a variety of OTC medications are available for your child when needed. (Vitamins and supplements are not regulated in the USA and therefore are not considered OTC medications.) These medications will be administered by Oak Hill nursing staff or other trained faculty/staff members.

The medications 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 OTC Medications to my child when necessary.

Signature:_____Date:_____

I give my child, _____, permission to possess and self-administer athletic supplements, including but not limited to pre-work out supplements, post-work out supplements, protein powder, etc. I understand that this is a privilege and if it is believed by the faculty & staff at Oak Hill Academy that my child is not being responsible in managing them, these products will be confiscated and my child will lose the privilege to possess them on campus.

(Parent Signature) (Date)