OAK HILL SCHOOL

Medical History and Contact Release

Please Print

39 Charlton Road, Scotia, NY 12302
518-399-5048 ext. 10 FAX 518-399-6140

Student Name _____ Date _____

List any ongoing medical problems your child has:

Food Allergies _____ Reaction _____
Medication Allergies _____ Reaction _____
Bee Sting Allergy? Yes _____ No _____
If yes, describe reaction _____
Required treatment _____

Illnesses and conditions child has had or has – give dates:

Anemia _____	Asthma _____
Chickenpox _____	Diabetes: Child ____ Family ____
German measles (Rubella) _____	Rheumatic Fever _____
Measles (Rubeola) _____	Frequent Colds _____
Scarlet Fever _____	Frequent Sore Throat _____
Mumps _____	Frequent Ear Infection _____
Pneumonia _____	Eye Problems _____
Heart Disease _____	Epilepsy _____
Speech Problem _____	Wears Glasses _____
Contact with Tuberculosis _____	Cleft Palate _____

Serious Accidents, Operations, Other Illnesses: _____
_____

Do you have medical insurance? Yes __ No __ Name of Insurance _____

In case of emergency, I give permission to call the doctor or dentist listed below.

Physician _____ **Phone** _____

Dentist _____ **Phone** _____

Name of hospital preferred in case of emergency: _____

_____ _____
Parent/Guardian signature Date

5/09