

Today's Date: _____

Kingston Hill Academy Health Record

Student: _____ Date of Birth: _____
Name: _____

Address: _____

City: _____ Zip: _____

Mother/Guardian Name: _____

Home Phone: _____ Cell: _____ Work: _____

Father/Guardian Name: _____

Home Phone: _____ Cell: _____ Work: _____

Kingston Hill Academy Emergency Contact/Consent Release

Any parent with sole or joint custody may pick up their child from school.

Please list the names of individuals that are authorized to accept responsibility for your child's care in case of illness, emergency or early dismissal in inclement weather when a parent with legal custody is unable to pick up the child from school.

If a child is under joint custody, then either party may add/delete any names on the emergency release list at any time throughout the year.

We ask that future requests be made in writing.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

(Please fill out both sides of this form completely)

MEDICAL HISTORY

(Check all that apply)

Asthma _____ Heart Condition _____ Seizure Disorder _____ Diabetes _____

Does your child have any physical, learning, or other disability that the school should be aware of in order to help your child achieve his/her education goals? Yes _____ No _____

If yes, please describe: _____

Is your child allergic to anything? Yes _____ No _____

If yes, please describe: _____

Drugs allergies (please list) _____

Food allergies (please list) _____

Does your child require an Epi-Pen for allergic reactions? Yes _____ No _____

Is your child currently being treated for any medical condition? Yes _____ No _____

If yes, please describe _____

Is your child currently on any medication(s)? Yes _____ No _____

If yes, please describe _____

In the past year has your child had a serious illness or accident that required hospitalization?

If yes, please describe _____

Your Child's physician _____

Date of next or last appointment _____

Your child's dentist _____

Date of next or last appointment _____

(Please fill out both sides of this form completely)