Today's Date: _____

Kingston Hill Academy
Health Record

Student Name: _____ Date of Brith: _____

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)