DISTRICT SCHOOL BOARD OF MADISON COUNTY
EMERGENCY AND HEALTH INFORMATION

Student's Name _____ Sex _____ Birthdate _____

Grade _____ Teacher _____ School _____

Student's Mailing Address _____ Phone _____
(If address or phone number changes, please contact school with the new information)

Directions to Home _____

_____

_____ Relationship: Employer Name, Address & Phone:
Male Head of Household (Last, First, Initial) ☐ Parent ☐ Guardian ☐ Other _____

_____ ☐ Parent ☐ Guardian ☐ Other _____
Female Head of Household (Last, First, Initial)

Person to Contact if Parent Listed Above Cannot Be Reached

Name	Relationship	Phone	Name	Relationship	Phone
Name	Relationship	Phone	Name	Relationship	Phone
Name	Relationship	Phone	Name	Relationship	Phone

_____ School Insurance? Medicaid Number (Required) Other Insurance? Kid Care?
Hospital Preference ☐Yes ☐No _____ ☐Yes ☐No ☐Yes ☐No

_____ _____
Physician's Name Phone Dentist's Name Phone

MEDICATIONS: Is the student taking any regular medication (including over-the-counter medications)? ☐Yes ☐No

_____ _____
_____ _____
_____ _____
_____ _____

Medication Allergies: ☐Yes ☐No (Life Threatening or Non-Severe)
_____
_____
_____

Food Allergies: ☐Yes ☐No (Life Threatening or Non-Severe)
_____
_____
_____

Other Allergies: ☐Yes ☐No
_____
_____
_____

HEALTH PROBLEMS: ☐History of Asthma ☐Active Asthma ☐Diabetes (Type 1 or Type 2) ☐ Seizures ☐Cardiac Condition ☐Nosebleeds ☐Sickle Cell Disease ☐Sickle Cell Trait ☐ ADD ☐ ADHD ☐ Psychiatric Condition ☐ Kidney Disorders ☐ Autism ☐Asperger's ☐ Cancer ☐ Migraines

List any others: _____

Record any injury or major Illness student has had: _____

_____

Does the child wear glasses? ☐ Yes ☐ No Does the child wear a hearing aid? ☐ Yes ☐ No

I hereby give consent for my child to receive an EpiPen injection if medically necessary. ☐ Yes ☐ No

I HEREBY GIVE CONSENT FOR MY CHILD TO PARTICIPATE IN THE FOLLOWING HEALTH SERVICES:

☐ SCOLIOSIS SCREENING (Curvature of the Spine) (6th & 7th Grades)
☐ PUBERTY CLASSES (5th & 6th Grade Girls & Boys)
☐ TOBACCO PREVENTION EDUCATION Prevention Surveys
☐ NUTRITION CLASSES (Age Appropriate)
☐ PEDICULOSIS SCREENING (Head Lice) (All Grade Levels)
☐ HIV/AIDS EDUCATION (K-12th Grade Appropriate)
☐ DENTAL HEALTH CLASSES (Age Appropriate)
☐ TEEN PREGNANCY PREVENTION EDUC. (Age Appropriate)

THE FOLLOWING SERVICES ARE DONE ROUTINELY:
Emergency Medical Care
First Aid
Head Lice Screenings (Targeted Grades)
Hearing & Vision Screening (Targeted Grades)
Weight & Height Screening (Targeted Grades)
Body Mass Index (Targeted Grades)

List any activity in which you do not want your child to participate.

I hereby give my consent for my child to participate in the School Health Services Program. In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact the physician indicated on this form and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary to provide care and treatment of my child. In the case of an accident or illness where immediate treatment of my child is not indicated but where (she)he is unable to remain at school, I request that the school contact me or my spouse to arrange transportation for my child. If the school is unable to contact either me or my spouse, I request that one of the persons listed on this form be contacted and requested to care for my child until I can be reached.

Parent or Guardian Signature Date

If my child is Medicaid eligible, I authorize the School District of Madison County, Florida to release and exchange my child's confidential information to agencies of the State of Florida which would allow Madison County Schools to receive Medicaid funding for exceptional student services provided to my child while at school.

Parent or Guardian Signature Date Date

The School Health Program of the Florida Department of Health in Madison County will be billing Medicaid for school clinic services for the school year 2017-2018 to help support the delivery of health care services throughout the district. By signing below, you are giving the School Health Program permission to access your child's public benefits to pay a share of the cost for services provided. At no time will you be required to incur out of pocket expenses for these services regardless of your child's Medicaid eligibility status. Any personally identifiable information about your child will not be disclosed to any other organization for any purpose except what has been noted above.

By signing below you are giving the School Health Program permission to utilize health information on the Emergency Health Form that is required by the Agency for Health Care Administration in order to verify Medicaid eligibility. You have the right to revoke this consent at any time. Failure to provide consent will not affect the health services your child is eligible to receive.

Parent or Guardian Signature Date Date