Leon County Schools
2018-2019 EMERGENCY & MEDICAL INFORMATION

STUDENT INFORMATION

To be completed by Parent/Guardian only. Use pen.

School_____

_____ _____ _____ _____ ____/___/____ _____
Student's Legal Last Name | Student's Legal First Name | MI | Nickname | Birth Date | Age

_____ _____ _____ _____
Grade | Homeroom Teacher/First Period | Sex/Race | Student Social Security Number

_____
Address/City/State/Zip

_____
Mailing Address (If different from residence address above)

Transportation from School
- After School Care ❒
- Car Pick Up ❒
- Van Carpool ❒
- Walk's With _____ ❒
- Bike ❒
- Drive ❒
- Bus # _____ ❒
- Day Care Name_____

PARENT/GUARDIAN INFORMATION

_____ _____ (h)_____(w)_____(c)_____
Mother's Name | Place of Employment | Phone numbers

_____ _____ (h)_____(w)_____(c)_____
Father's Name | Place of Employment | Phone numbers

_____ _____ (h)_____(w)_____(c)_____
Guardian's Name (if applicable) | Place of Employment | Phone numbers

STUDENT LIVES WITH: ❒ Both Parents (same address) ❒ Mother ❒ Father ❒ Other _____
CUSTODY: _____
(List any special custody arrangements. *Appropriate legal documentation must be on file in a student's cumulative folder*)

Siblings at this school: _____

➔Last Name, For Office Use Only. **➔ First Name**

DOCTOR AND INSURANCE INFORMATION

It is important that you provide information regarding your child's health conditions and health insurance to assist us in the case of an emergency.

_____ _____ _____
Doctor's Name | Address | Telephone Number

_____ _____ _____
Specialist Doctor's Name | Address | Telephone Number

HEALTH INSURANCE: ❒ **Healthy Kids Acct#**_____ ❒ **Medicaid ID #**_____
❒ **Other Insurance** _____ **Policy #**_____
❒ **Children's Medical Services** Name of case manager: _____
❒ **None at this time.**

HEALTH CONDITIONS (Diagnosed by a healthcare provider)

❒ **ALLERGIES** (specify severity below) ❒ insects ❒ medicine ❒ food ❒ other_____ ❒ **Requires EpiPen** ❒ Requires Benadryl/antihistamine	❒ **ASTHMA** ❒ Mild ❒ Moderate ❒ Severe ❒ Requires medication/inhaler available at school	❒ **SEIZURES/EPILEPSY** Date of last seizure _____ ❒ Requires Diastat	❒ **DIABETES** ❒ Type 1 ❒ Pump ❒ Pen ❒ Type 2	❒ **ADD** Medication Required? ❒ Home ❒ School ❒ **ADHD** Medication Required? ❒ Home ❒ School

- ❒ Anemia
- ❒ Arthritis
- ❒ Cancer (specify below)
- ❒ Cerebral Palsy
- ❒ Cystic Fibrosis
- ❒ Ear Infections (repeated)
- ❒ Emotional Difficulties (specify below)
- ❒ Gastrointestinal Condition
- ❒ Headaches (specify below)
- ❒ Hearing Impairment
- ❒ Hemophilia
- ❒ Heart Disease/Murmur (specify below)
- ❒ High Blood Pressure
- ❒ Hypoglycemia
- ❒ Kidney Disease
- ❒ Leukemia
- ❒ Muscular Dystrophy
- ❒ Motor Impairment
- ❒ Nosebleeds
- ❒ Physical Impairment
- ❒ Pregnancy
- ❒ Psychological Disorder (specify below)
- ❒ Scoliosis
- ❒ Sickle Cell Disease
- ❒ Sickle Cell Trait
- ❒ Skin Condition (specify below)
- ❒ Speech Impairment
- ❒ Transplant (specify below)
- ❒ Urological Conditions
- ❒ Other (specify below)
- ❒ Religious Restrictions
- ❒ ESE (specify below) (exceptional student education)
- ❒ None Known

Religious restrictions (specify):_____

Specify severity of health conditions/Specify restrictions on activity and any accommodations needed while at school:

_____

_____

List all medications (prescription and non-prescription, including "as needed" and emergency meds) that student takes
AT HOME:_____

AT SCHOOL:_____

******TURN FORM OVER TO COMPLETE – Signatures Needed on Back****** **Rev. 2/18**

HEALTH SCREENINGS

For Office Use Only → Last Name, → First Name

The Leon County Health Department and Leon County Public Schools coordinate annually to provide state mandated health screenings for students in Leon County Schools. Health screenings may help identify the need for further evaluation. Florida law requires that parents be informed in writing at the beginning of each school year that children will receive such services. **This serves as that notification.**

If no box is checked, your child will be screened.

HEALTH SCREENING DESCRIPTIONS

Vision and Hearing: Identifies possible vision and hearing problems using a standardized procedure.
Scoliosis: Observes for possible abnormal curvature of the spine while wearing everyday clothing.
Body Mass Index: Measures height and weight to calculate Body Mass Index (BMI) while wearing normal clothing without shoes.
The BMI calculation tells us if a child is in the normal range for height and weight, or is outside the norm and has increased potential to develop certain chronic diseases during childhood or adulthood.

HEALTH SCREENING TYPE	GRADE(S)
Vision	Grades K, 1, 3 & 6
Hearing	Grades K, 1 & 6
Scoliosis (Abnormal curvature of the spine)	Grades 6
Body Mass Index (Height and Weight)	Grades 1, 3 & 6

I **do not** want my child to participate in the following health screenings (check all that apply):

- ☐ Vision Screening
- ☐ Hearing Screening
- ☐ Scoliosis Screening
- ☐ Body Mass Index

➡ _____ _____
Parent Signature Date

EMERGENCY CONTACTS and PARENTAL CONSENT

Child Pickup/Emergencies: Should my child become ill or injured during the school day and the school is unable to contact me, I hereby give the school permission to contact one or more of the following persons to pick up my child at school and care for my child during my absence. ***(Must be at least 18 years of age.)***

1._____/_____/_____ 3._____/_____/_____
Name Relationship Telephone Name Relationship Telephone

2._____/_____/_____ 4._____/_____/_____
Name Relationship Telephone Name Relationship Telephone

In case of accident or serious illness during the school day, I request that the school contact me. In case of an emergency, I hereby give the school permission for my child to be transported by Emergency Medical Services to the hospital and given the necessary treatment. **All students will receive care for injuries and emergencies.** I understand that I will be responsible for any and all related charges. I understand that it is the parent's/guardian's responsibility to notify the school of any change in this information throughout the school year.

➡ _____ _____
Parent/Guardian Signature Date

Leon County Schools relies on Medicaid reimbursements to support the delivery of health care services in clinics throughout the school district. By signing below you are giving Leon County Schools permission to utilize information contained on this form that is required by the Agency for Health Care Administration in order to verify Medicaid eligibility. In addition, you are giving permission for Leon County Schools to access your child's public benefits to pay a share of the cost for services provided as referenced in the child's Individual Educational Plan (if applicable). 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.

➡ _____ _____
Parent/Guardian Signature Date