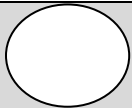


# Leon County Schools

## 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

Mother's Name \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
 Place of Employment \_\_\_\_\_ Phone numbers \_\_\_\_\_

Father's Name \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
 Place of Employment \_\_\_\_\_ Phone numbers \_\_\_\_\_

Guardian's Name (if applicable) \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
 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: \_\_\_\_\_

### 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)

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> <b>ALLERGIES</b> (specify severity below)<br><input type="checkbox"/> insects <input type="checkbox"/> medicine<br><input type="checkbox"/> food <input type="checkbox"/> other _____<br><input type="checkbox"/> <b>Requires EpiPen</b><br><input type="checkbox"/> Requires Benadryl/antihistamine | <input type="checkbox"/> <b>ASTHMA</b><br><input type="checkbox"/> Mild<br><input type="checkbox"/> Moderate<br><input type="checkbox"/> Severe<br><input type="checkbox"/> Requires medication/inhaler available at school | <input type="checkbox"/> <b>SEIZURES/EPILEPSY</b><br>Date of last seizure _____<br><input type="checkbox"/> Requires Diastat | <input type="checkbox"/> <b>DIABETES</b><br><input type="checkbox"/> Type 1 <input type="checkbox"/> Pump<br><input type="checkbox"/> Pen<br><input type="checkbox"/> Type 2 | <input type="checkbox"/> <b>ADD</b> Medication Required?<br><input type="checkbox"/> Home <input type="checkbox"/> School<br><input type="checkbox"/> <b>ADHD</b> Medication Required?<br><input type="checkbox"/> Home <input type="checkbox"/> School |
|---|---|--|--|---|

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Cancer (specify below)<br><input type="checkbox"/> Cerebral Palsy<br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> Ear Infections (repeated)<br><input type="checkbox"/> Emotional Difficulties (specify below)<br><input type="checkbox"/> Gastrointestinal Condition<br><input type="checkbox"/> Headaches (specify below) | <input type="checkbox"/> Hearing Impairment<br><input type="checkbox"/> Hemophilia<br><input type="checkbox"/> Heart Disease/Murmur (specify below)<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Hypoglycemia<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Leukemia<br><input type="checkbox"/> Muscular Dystrophy<br><input type="checkbox"/> Motor Impairment | <input type="checkbox"/> Nosebleeds<br><input type="checkbox"/> Physical Impairment<br><input type="checkbox"/> Pregnancy<br><input type="checkbox"/> Psychological Disorder (specify below)<br><input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Sickle Cell Disease<br><input type="checkbox"/> Sickle Cell Trait<br><input type="checkbox"/> Skin Condition (specify below)<br><input type="checkbox"/> Speech Impairment | <input type="checkbox"/> Transplant (specify below)<br><input type="checkbox"/> Urological Conditions<br><input type="checkbox"/> Other (specify below)<br><input type="checkbox"/> Religious Restrictions<br><input type="checkbox"/> ESE (specify below)<br>(exceptional student education)<br><input type="checkbox"/> 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:** \_\_\_\_\_

↑ Last Name, For Office Use Only. First Name ↓

