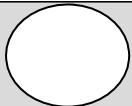


Leon County Schools

2017-2018 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	<input type="checkbox"/>
Car Pick Up	<input type="checkbox"/>
Van Carpool	<input type="checkbox"/>
Walk's With _____	<input type="checkbox"/>
Bike	<input type="checkbox"/>
Drive	<input type="checkbox"/>
Bus # _____	<input type="checkbox"/>
Day Care Name _____	<input type="checkbox"/>

PARENT/GUARDIAN INFORMATION

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

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

Guardian's Name (if applicable) _____ Place of Employment _____ (h) _____ (w) _____ (c) _____ 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.

Last Name, First Name
For Office Use Only.

HEALTH CONDITIONS (Diagnosed by a healthcare provider)

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

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

HEALTH SCREENINGS

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

Vision
Hearing
Scoliosis (Abnormal curvature of the spine)
Body Mass Index (Height and Weight)

GRADE(S)

Grades K, 1, 3 & 6
Grades K, 1 & 6
Grades 6
Grades 1, 3 & 6

↓ Last Name,
For Office Use Only

↑ First Name

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