SCHOOL BOARD OF MADISON COUNTY
EMERGENCY AND HEALTH INFORMATION

S.S. #_____

Student's Name_____ Sex____ Birthdate_____ Bus #____

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

_____ 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

ALLERGIES: Medication_____ Food_____ Other_____

HEALTH PROBLEMS: ☐Asthma ☐Diabetes ☐Seizures ☐Heart Condition ☐Nosebleeds ☐Sickle Cell ☐ADD/ADHD

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
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 (s)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.

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.

_____ _____

Date Parent or Guardian

All individuals are advised that social security numbers are confidential and may only be released under such circumstances as set forth in Florida's Public Records Act. The Madison County School Board is required to request student social security numbers for use in student enrollment and it is included as part of the student's demographic record. (F.S. 1006.06)