

# Wakulla County Schools EMERGENCY AND MEDICAL 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 \_\_\_\_\_

**Transportation from School**

After School Care

Car Pick Up

Van Carpool

Walk's With \_\_\_\_\_

Bike

Drive

Bus # \_\_\_\_\_

Day Care Name: \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_

Mailing Address (If different from residence address above) \_\_\_\_\_

Mother's Name _____	Place of Employment _____	(h) _____	(w) _____	(c) _____
Father's Name _____	Place of Employment _____	(h) _____	(w) _____	(c) _____
Guardian's Name _____	Place of Employment _____	(h) _____	(w) _____	(c) _____

**STUDENT LIVES WITH:** (check one)  Both Parents (same address)  Mother  Father  Other \_\_\_\_\_

**CUSTODY:** \_\_\_\_\_  
(List any special custody problems. Appropriate legal documentation must be on file in a student's cumulative folder)

**RELIGIOUS RESTRICTIONS/SPECIFY:** \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

Children's Medical Services:  Yes  No If yes, name of case manager: \_\_\_\_\_

**HEALTH INSURANCE:**  Healthy Kids  Medicaid  ID # \_\_\_\_\_  Other Policy # \_\_\_\_\_  None

**HEALTH CONDITIONS:**

<input type="checkbox"/> Allergy to insects – specify severity below <input type="checkbox"/> Allergy to medicine – specify severity below <input type="checkbox"/> Allergy to food – specify severity below <input type="checkbox"/> Allergy to other – specify severity below <input type="checkbox"/> EpiPen <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis – specify below <input type="checkbox"/> Asthma: (requiring treatment at school)	<input type="checkbox"/> Cancer – specify below <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Diabetes (Type _____) <input type="checkbox"/> Drug Dependency – specify below <input type="checkbox"/> Ear Infection/Repeated <input type="checkbox"/> Epilepsy/Seizures (date of last seizure _____) <input type="checkbox"/> Gastrointestinal Condition <input type="checkbox"/> Headache – specify type below <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Hemophilia	<input type="checkbox"/> Heart Disease/Murmur– specify below <input type="checkbox"/> Hernia – specify below <input type="checkbox"/> High blood pressure <input type="checkbox"/> Hyperactivity (ADD; ADHD) <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 Problems – specify below <input type="checkbox"/> Scoliosis <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sickle Cell trait <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Transplant – specify below <input type="checkbox"/> Urological Conditions <input type="checkbox"/> Visual Correction Glasses <input type="checkbox"/> Visual Corrective Contacts <input type="checkbox"/> Visual Problems – specify below <input type="checkbox"/> Other – specify below
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Specify severity of health conditions/Specify restrictions on activity and any accommodations needed while at school (may use other side of this form if additional space is needed): \_\_\_\_\_

List all medications (plus doses, time, etc.) that student takes AT HOME OR SCHOOL: \_\_\_\_\_

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

(1) Name _____	Relationship _____	Telephone _____	(3) Name _____	Relationship _____	Telephone _____
(2) Name _____	Relationship _____	Telephone _____	(4) 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. 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.

I give my permission for the information on this form to be reviewed and utilized by Wakulla County Schools and Wakulla County Health Department staff to assist in the provision of school health services. Wakulla County Schools utilizes Medicaid reimbursement funds to provide health care services to students in the district. In order to determine which students are Medicaid eligible we must be able to provide certain information about students to the Agency for Health Care Administration's fiscal agent (ACS). Any personally identifiable information about your child will not be disclosed to any other organization for any other purpose except that which was noted above. By signing below you are giving Wakulla County Schools permission to utilize information contained on this form to verify which students are/are not Medicaid eligible. Eligibility for Medicaid does not in any way affect the services your child receives at school.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_