Student Emergency Information Card

The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by school staff on a need-to-know basis. **This form is required for access to all health services, as well as field trips and extra-curricular activities.** It is the parent's responsibility to provide the school with any changes or updates to your child's information.

Student Name

Last	First	Middle

Parent Name

Last	First	Phone #

Address

Medication

Does your child take medication? ☐ Yes ☐ No

If your child requires medication at school, all medication sent to the school must be in original prescription container with a current date and the child's name. Before medication can be dispensed, a "Permission to Administer Medication" form must be completed and signed by the physician and the parent and must be on file at the school.

Medication	Dosage	Hour(s) Given

Health Insurance Information

Please check appropriate box: ☐ Family Health Insurance ☐ Florida Healthy Kids ☐ Florida Kid Care ☐ No Health Insurance ☐ Medicaid # _____ ☐ Other Insurance_____ Policy #_____

Vision and Hearing

Does your child wear contacts/glasses? ☐ Yes ☐ No

Does your child wear hearing aid(s)? ☐ Yes ☐ No

Health Care Providers

	Name	Phone
Physician		
Dentist		

Medical Conditions

Check all that apply:

- ☐ Asthma If checked, uses inhaler? ☐ Yes ☐ No ☐ On daily medication?
- ☐ Seizures If checked, on medication? ☐ Yes ☐ No
- ☐ Diabetes If checked, insulin dependent? ☐ Yes ☐ No
- ☐ Movement Limitations _____
- ☐ Recent illness/hospitalization/surgery (describe) _____
- ☐ Other _____
- ☐ Severe allergies? If checked, please specify: _____
- ☐ Food/environmental
- ☐ Insect stings/bees
- ☐ Medicines/Drugs
- ☐ Other

Allergies require:

- ☐ EpiPen
- ☐ Benadryl
- ☐ Other

Release of Medical Information

I understand and agree that certain educational health related records of my child will be shared with the district's health care partners (which include PanCare of Florida, Inc., & the Department of Health, Bay County) as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by the health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records. I further authorize the district's health care partners to contact my child's pediatrician(s) or physician(s) to obtain personal medical information as it pertains to student health services.

I hereby consent to my child's medical information, parental contact information, and other health information (collected from health services provided at school, including information stored electronically) being shared with emergency personnel and health department officials to address conditions of public health importance, including information to meet and to prepare for potential or confirmed health conditions.

Emergency Treatment

The school has my permission to seek emergency medical treatment in case of a serious accident or illness. In case of an accident or illness where immediate treatment of my child is not indicated but where he/she is unable to remain in school, I request that the person(s) listed on FOCUS Parent Portal be contacted and requested to care for my child in the event I cannot be reached. I also authorize the exchange of medical information as necessary to support the continuity of care for my child.

I understand I will not receive a bill for any services not covered by insurance however, I do not give consent for Bay District Schools & its contracted partners to bill my insurance/Medicaid for services provided. Parent Initials _____

Medical and other information will be disclosed without consent from the parent/eligible student in case of health emergencies, as permissible by FERPA. The school will call for emergency medical care as deemed necessary. Emergency transportation to a health care facility, as determined by paramedics, will be authorized.

Parent Signature _____ **Date**_____

Continue on other side ➡

PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES 2019-2020

School:_____ Teacher:_____ Grade:_____

WHAT IS THE SCHOOL HEALTH SERVICES PLAN?

This School Health Services Program is designed to appraise, protect & promote the health of our students as well as provide preventive and emergency school-based health services in accordance with our local School Health Services Plan. The School Health Services Plan is jointly developed and these services are provided by health care professionals under the direction of Bay District Schools Administration, the Florida Department of Health Bay County and PanCare of Florida, Inc.

PANCARE OF FLORIDA, INC. SCHOOL HEALTH SERVICES PROGRAM INCLUDES:

The following healthcare services are provided by PanCare of Florida, Inc., as a part of the jointly developed School Health Services Plan. I give consent to the following services (***parents initial items to which you consent***):

Initials:_____Health Support Technician Services

- Medication distribution to students by Health Support Technicians
- Basic First Aid Services

Initials:_____School and Sports Physicals

- Physicals provided by a Florida Licensed Medical Provider

Initials:_____Preventative Dental Services

- Dental exams provided by a Florida Licensed Dentist
- Dental Cleanings provided by a Florida Licensed Dental Hygienist
- Dental Sealants applied to molars as needed by a Florida Licensed Dental Hygienist

SCHOOL HEALTH SCREENINGS

Initials:_____ Health Screenings

- Florida Statue 381.0056(7)(d), mandates regular health screenings to public school students.
- The screenings include vision, hearing, height and weight, Body Mass Index (BMI) and scoliosis. As well as a behavioral health well-being questionnaire for students 12 years & older. They are offered in an effort to decrease health barriers to learning and may be performed individually or in groups.

PRINT STUDENT'S FIRST AND LAST NAME:_____ Date of Birth:_____

PRINT PARENT'S FIRST AND LAST NAME:_____

PARENT/LEGAL GUARDIAN SIGNATURE:_____Date:_____

The above consent statements will remain in effect until the parent/legal guardian informs the principal in writing of any changes.

Continue on other side ➡