Marion County Public Schools
Developing Successful Citizens -- Every Student, Every Day

EMERGENCY & MEDICAL INFORMATION

512 SE 3RD Street, Ocala FL 34471 • PO Box 670
(352) 671-7700 • (352) 671-7788 • www.marionschools.net
FRS (800) 955-8770 • (800) 955-8771 (TTY)

This form is to be completed annually by parent/guardian ONLY. Please notify school of any changes in this information throughout the school year.

STUDENT INFORMATION: *PLEASE PRINT LEGIBLY*

Last Name: _____ First Name: _____ Middle Name: _____ Jr., II, etc.: _____

Birth Date: ____/____/____ Age: _____ Grade: _____ Gender: _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

PARENT/GUARDIAN INFORMATION:

Mother/Guardian: _____ Employer: _____ Work Phone: _____

Address (if different): _____ Home Phone: _____ Cell Phone: _____

Father/Guardian: _____ Employer: _____ Work Phone: _____

Address (if different): _____ Home Phone: _____ Cell Phone: _____

ADDITIONAL STUDENT INFORMATION:

STUDENT LIVES WITH: (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____

(Attach any restraining order or similar judicial pleading that prohibits parental access. If a court-adopted parenting plan is in effect, attach a copy)

OTHER BROTHERS/SISTERS ENROLLED IN MARION COUNTY PUBLIC SCHOOLS:

Name: _____ Name: _____ Name: _____

Grade: _____ Grade: _____ Grade: _____

SPECIAL HEALTH PROBLEMS AND/OR NEEDS REQUIRING MEDICAL ASSISTANCE AT SCHOOL:

☐ ADHD/ADD
☐ Non-Life Threatening Allergies (Specify) _____
☐ Medication Allergies (Specify) _____
☐ Asthma
☐ Bleeding Disorder
☐ Cerebral Palsy
☐ Cancer
☐ Cardiac Conditions
☐ Crohn's Disease
☐ Cystic Fibrosis
☐ Type 2 Diabetes
☐ Type 1 Diabetes
☐ History of Asthma
☐ Hypoglycemic
☐ Kidney Disorder
☐ Other Condition (Specify) _____
☐ Psychiatric Conditions
☐ Life Threatening Allergies (Specify) _____
☐ Seizure Disorder
☐ Sickle Cell Disease
☐ Spina Bifida
☐ Tracheostomy

Medical Services needed at SCHOOL: ***(Parent/Guardian authorization & physician order required)*** _____

SCHOOL USE ONLY: Received by _____ Date _____ Reviewed by nurse _____ Date _____ ☐ Comments on back

CHILD PICK-UP/EMERGENCIES:

I agree that the school may release my child to the following people and provide pertinent information related to this release. Contacts must be updated yearly. Any previous contacts not listed below will be removed. Enter contact names as they would appear on the driver's license.

(1) Full Name: _____ Relationship: _____ Phone: _____

(2) Full Name: _____ Relationship: _____ Phone: _____

(3) Full Name: _____ Relationship: _____ Phone: _____

(4) Full Name: _____ Relationship: _____ Phone: _____

I understand and agree to the following:

- My child's records and information may be shared with the School Board's health care partners as needed to provide and evaluate health care services.
- If my child is or becomes Medicaid eligible, reimbursable services may be billed to Medicaid and my child's information and records may be provided to Medicaid and/or the School Board's Medicaid processing agents or the School Board's health care partners. Consent for Medicaid billing may be revoked at any time and if consent is revoked, these services will be provided at no cost.
- In case of emergency, my child may be transported by Emergency Medical Services to a hospital and provided treatment, and I am responsible for charges related to the transportation and medical treatment.

Student's Physician (Print): _____ **Phone:** _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____

SCHOOL USE ONLY	School Name:	Entry Date: / /	School Year : /
	Teacher Name:	Student ID:	

~ An Equal Opportunity School District ~

Distribution: Original-Office Copy-Health Clinic Copy-Guidance