Form Updated in SIS By: _____

Date Updated in SIS: _____

DISTRICT SCHOOL BOARD OF MADISON COUNTY
DEMOGRAPHIC, EMERGENCY, AND HEALTH INFORMATION UPDATE FORM

School: _____ Current Grade: _____ Date: _____

Student's Full Legal Name: _____ (Last Name) _____ (First Name) _____ (Middle Name) _____ (Suffix)

Student's Date of Birth: _____ (Month) / _____ (Day) / _____ (Year) This student is a child of an active Military Family. Yes ☐ No ☐

Parent / Guardian Information

Persons listed below are the legal guardian of the student and live with the student at the below listed physical address. These persons have legal rights to student confidential information, check student out of school, and sign any documents requiring parent / guardian consent, acknowledgment, or affirmation.

_____ (Legal Guardian #1 Full Name) _____ (Relationship to Student)
Home Phone # _____
Cell Phone # _____
Email Address: _____ Work Phone # _____

_____ (Legal Guardian #2 Full Name) _____ (Relationship to Student)
Home Phone # _____
Cell Phone # _____
Email Address: _____ Work Phone # _____

Physical Residential Address:

House # | Street Direction | Street Name | Apt. # / Lot # | City | State | Zip Code

Mailing Address (if different from Physical Residential Address):

House # or PO Box | Street Direction | Street Name | Apt. # / Lot# | City | State | Zip Code

Is there a shared-custody or parenting plan/agreement in effect? Yes ☐ No ☐

Is there a restraining order in effect? *Yes No ***If Yes, provide name and relationship of person the order is against below.***

_____ (Name of Person Restraining Order is against) _____ (Relationship to Student)

Is the Child under DCF (Department of Children and Families) Supervision? Yes ☐ No ☐

Emergency Contact Information

Persons listed below will attempted to be contacted, in the order listed, in the event that we are unable to contact the parent / guardians listed above. ***You must notate below if the person listed is allowed to pick-up / check-out your student from school.***

_____ (Emergency Contact #1 Full Name) _____ (Relationship to Student)
Allowed to pick student up from school? Yes ☐ No ☐
Home Phone # _____
Cell Phone # _____
Work Phone # _____

_____ (Emergency Contact #2 Full Name) _____ (Relationship to Student)
Allowed to pick student up from school? Yes ☐ No ☐
Home Phone # _____
Cell Phone # _____
Work Phone # _____

_____ (Emergency Contact #3 Full Name) _____ (Relationship to Student)
Allowed to pick student up from school? Yes ☐ No ☐
Home Phone # _____
Cell Phone # _____
Work Phone # _____

_____ (Emergency Contact #4 Full Name) _____ (Relationship to Student)
Allowed to pick student up from school? Yes ☐ No ☐
Home Phone # _____
Cell Phone # _____
Work Phone # _____

_____ (Emergency Contact #5 Full Name) _____ (Relationship to Student)
Allowed to pick student up from school? Yes ☐ No ☐
Home Phone # _____
Cell Phone # _____
Work Phone # _____

Student Health Insurance / Physician Information

Does Student have:

School Insurance? Yes ☐ No ☐

Medicaid? ***If Yes, List Medicaid Number (Required)*** *Yes ☐ No ☐ _____ (*Medicaid Number (Required))

Other Private Insurance? Yes ☐ No ☐

Kid Care? Yes ☐ No ☐

_____ (Physician's Name) _____ (Phone Number) _____ (Dentist's Name) _____ (Phone Number)

Medication Information

Is the student taking any daily medication(s) at home (including over-the-counter medications)? *Yes ☐ No ☐

If Yes, list medications below.

_____ _____

_____ _____

Health Problems Information (Please check the box(es) or list any health problems/issues your student may have)

☐ Active Asthma	☐ Nosebleeds	☐ Kidney Disorder	☐ Migraines
☐ Diabetes [Type 1 or Type 2] (Please circle one)	☐ ADHD	☐ Autism	
☐ Seizures	☐ Sickle Cell Trait	☐ Asperger's	
☐ Cardiac Conditions	☐ Psychiatric Condition	☐ Cancer	

Please list any major injury, surgery, illness, or medical conditions not listed above that the student has had: _____

Does the student require special circumstances related to the medical condition(s)? *Yes ☐ No ☐ ***If Yes, please explain below:***

_____

_____

_____

*****Provide detailed notes from the student's physician to the school clinic of any medical issues requiring special circumstances.***

Has the student been referred for a mental health condition? *Yes ☐ No ☐

Does the student wear glasses or contacts? Yes ☐ No ☐ Does the student wear a hearing aid? Yes ☐ No ☐

Allergy Information (Please notate any allergies your student may have)

Medication Allergies	*Yes ☐ No ☐ ***If Yes, list below:***	***Life Threatening requiring Epi-pen or Benadryl?***	**Food Allergies**	*Yes ☐ No ☐ ***If Yes, list below:***	***Life Threatening requiring Epi-pen or Benadryl?***
_____		Yes ☐ No ☐	_____		Yes ☐ No ☐
_____		Yes ☐ No ☐	_____		Yes ☐ No ☐
_____		Yes ☐ No ☐	_____		Yes ☐ No ☐

Health Services Information and Consent

I HEREBY GIVE CONSENT FOR MY CHILD TO PARTICIPATE IN THE FOLLOWING HEALTH SERVICES:

SCOLIOSIS SCREENING (Curvature of the Spine) (7th Grade)	TOBACCO PREVENTION EDUCATION (Prevention Surveys)	DENTAL HEALTH CLASSES (Age Appropriate)
PUBERTY CLASSES (5TH & 6TH Grade Girls & Boys)	NUTRITION CLASSES (Age Appropriate)	TEEN PREGNANCY PREVENTION EDUCATION (Age Appropriate)
PEDICULOSIS SCREENING (Head Lice) (All Grade Levels as Needed)	HIV/AIDS EDUCATION (K-12th Grade Appropriate)	

THE FOLLOWING SERVICES ARE DONE ROUTINELY:
Emergency Medical Care
First Aid
Head Lice Screening (Targeted Grades)
Hearing & Vision Screening (Targeted Grades)
Weight & Height Screening (Targeted Grades)
Body Mass Index (Targeted Grades)

List any activity/service 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 (she)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.

_____ _____
Parent or Guardian Signature Date

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.

_____ _____
Parent or Guardian Signature Date

The School Health Program of the Florida Department of Health in Madison County will be billing Medicaid for school clinic services for the school year 2018-2019 to help support the delivery of health care services throughout the district. By signing below, you are giving the School Health Program permission to access your child's public benefits to pay a share of the cost for services provided. 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.

By signing below you are giving the School Health Program permission to utilize health information on the Emergency Health Form that is required by the Agency for Health Care Administration in order to verify Medicaid eligibility. You have the right to revoke this consent at any time. Failure to provide consent will not affect the health services your child is eligible to receive.

_____ _____
Parent or Guardian Signature Date

Updated 2/26/2024