Student's Name ________________ ________________ ________________
First Middle Last

Grade: ______________ DOB: ________________
MEDICAID # (If applicable): __________________ SS#: ________________________

STUDENT **HEALTH** INFORMATION FOR REGISTRATION AND CONSENT FOR TREATMENT FOR DURATION OF ATTENDANCE IN FLORENCE COUNTY SCHOOL DISTRICT #3

Has your child ever had any of the following medical problems? Check all answers that apply:

Asthma ____	Fainting Spells ____	Learning problems ____
Low iron in blood _____	Heart problems (murmur) ______	Sickle Cell disease (not trait) _____
Diabetes _____	Frequent Ear infections ____	Bed wetting, Kidney or bladder Problems ____
Migraine headaches _____	Skin problems ____	Wears glasses _____
Epilepsy (fits or seizures) ____	Vision problems ____	Mental/Behavior problems ______
Bone/muscle problems ______	Brain or spinal Cord problems ____	ADD/ADHD _________
(Pain, trouble walking)	Hearing problems ______	Other ______

FAMILY DOCTOR : ______________________ DOCTOR'S PHONE #: ___________________
Medical Alerts: ___________________________________

Is your child allergic to any of the following? Check all that apply & list what your child is allergic to and the kind of reaction they have.

____**food(s)**____
____**medicines**____
____**insect stings**______________________________**Is an epipen needed? Yes ____ No ____**

Is your child on medication that he/she will need to take at school? Yes ____ No ___

If yes, give the name of the medication: ____

Does your child use an asthma inhaler or nebulizer? Yes _____ No _____

EMERGENCY NAMES AND NUMBERS

These individuals are authorized to pick up my child other than myself

Contact Name	Contact Relationship	Contact Phone #
___________________________	___________________________	______________________
___________________________	___________________________	______________________
___________________________	___________________________	______________________

I give my permission for my child to receive prescription medication or medical treatment as deemed necessary by the school nurse/CNA, or school designee in nurse/CNA's absence. ***Over the counter medication may only be given by Nurse/CAN.*** Prescription medications may be given at the school with **SIGNED PRESCRIPTION AND PROPERLY LABELED CONTAINER FROM THE PHARMACIST. (This medication must be brought to the school by an adult.)**
In case of an emergency and **I CANNOT BE REACHED** I would like my child transported to the nearest emergency room by EMS. I understand that I am responsible for all expenses associated with the emergency.
My signature also gives permission for release/obtain information to/from physicians, other state agencies and Immigration Registry.

____________________________________ ____________________
Parent/Guardian Signature **Date**

____
(Parent/Guardian-Print Name)

____
(Parent/Guardian Day-time phone cell number and work number)

____
(Parent/Guardian Mailing Address and Physical Address, City, State, Zip)