Students Name

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/CNA***
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)