You must complete both sides of this card and return to the school as soon as possible.

Primary phone _____

The School Board of St. Lucie County

Emergency Information

ID # _____
AM Bus _____
PM Bus _____

Date _____ Student's Name _____ Grade _____ Homeroom _____

* Social Security # _____ Student's Date of Birth _____

* SS# is collected in order to identify students within the district computer system, Medicaid billing, if eligible, and program follow-up.

Street Address:

Street _____ City _____ Zip Code _____

Mailing Address if Different:

Street or P.O. Box _____ City _____ Zip Code _____

Parent/Guardian Information

Father/Male Guardian's Name _____ Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Mother/Female Guardian's Name _____ Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Other adults who can be contacted if your child becomes ill and we are unable to reach you at your home or work:

Name _____ Home Phone _____ Work Phone _____

Name _____ Home Phone _____ Work Phone _____

Name _____ Home Phone _____ Work Phone _____

I understand that in case of emergency, my child will be taken to a hospital and given the necessary treatment. I understand that I am to pay the bill, including emergency transport. I understand that certain educational records of my child will be shared with the District Health Care Partners as needed to provide and evaluate health services to students. I also understand that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a Legitimate Educational Purpose for accessing such treatment records. I certify that I have read all of the information on this form, front and back, and that it is all true and correct.

❒ yes ❒ no : I give my consent to allow the school district and their health care partners the ability to determine Medicaid eligibility, using my child's DOB and SS#, and , if eligible, to bill Medicaid for any services for which my child is eligibile.

Parent/Guardian's Signature _____ **Date** _____

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Parent/Guardian's Signature _____ **Date** _____

My Child's Doctor is _____ Number _____

Medical Information:

Condition	Currently Being Treated Y or N	Medication for Condition	Condition	Currently Being Treated Y or N	Medication for Condition
❑ ADHD			❑ Tourette's		
❑ Epilepsy/seizures			❑ Cerebral Palsy		
❑ Asthma			❑ Muscular Dystrophy		
❑ Diabetes			❑ Cancer		
❑ Heart Condition			❑ Sickle Cell		
❑ Kidney/bladder			❑ Bleeding Disorder		
❑ Headaches			❑ Psychiatric Condition		

❑ Other, please specify _____

Allergies to Medications: ❑ Yes ❑ No Specify Medication Name(s): _____

Allergic Reaction to bee stings, ant bites, food: ❑ Yes ❑ No Specify : _____

Can you provide medical documentation of the above?: ❑ Yes ❑ No

Pollen and Other Allergies: ❑ Yes ❑ No Specify allergy and medications: _____

Name(s) of Brothers and Sisters:	DOB	School

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My Child's Doctor is _____ Number _____

Medical Information:

Condition	Currently Being Treated Y or N	Medication for Condition	Condition	Currently Being Treated Y or N	Medication for Condition
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❑ Diabetes			❑ Cancer		
❑ Heart Condition			❑ Sickle Cell		
❑ Kidney/bladder			❑ Bleeding Disorder		
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❑ Other, please specify _____

Allergies to Medications: ❑ Yes ❑ No Specify Medication Name(s): _____

Allergic Reaction to bee stings, ant bites, food: ❑ Yes ❑ No Specify : _____

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Name(s) of Brothers and Sisters:	DOB	School

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