

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

**The School Board of St. Lucie County
Emergency Information**

ID # _____
AM Bus _____
PM Bus _____
Grade _____ Homeroom _____

Primary phone _____

Date _____ Student's Name _____

* 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 eligible.

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

My Child's Doctor is _____ Number _____

Medical Information:	Currently Being Treated	Medication for Condition	Condition	Currently Being Treated	Medication for Condition
Condition	Y or N		Condition	Y or N	
<input type="checkbox"/> ADHD	_____	_____	<input type="checkbox"/> Tourette's	_____	_____
<input type="checkbox"/> Epilepsy/seizures	_____	_____	<input type="checkbox"/> Cerebral Palsy	_____	_____
<input type="checkbox"/> Asthma	_____	_____	<input type="checkbox"/> Muscular Dystrophy	_____	_____
<input type="checkbox"/> Diabetes	_____	_____	<input type="checkbox"/> Cancer	_____	_____
<input type="checkbox"/> Heart Condition	_____	_____	<input type="checkbox"/> Sickle Cell	_____	_____
<input type="checkbox"/> Kidney/bladder	_____	_____	<input type="checkbox"/> Bleeding Disorder	_____	_____
<input type="checkbox"/> Headaches	_____	_____	<input type="checkbox"/> Psychiatric Condition	_____	_____
<input type="checkbox"/> 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____