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

Primary phone _____

St. Lucie Public Schools

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** _____

My Child's Doctor is _____ Medicaid ☐ Yes ☐ No Number _____

Insurance Provider _____ 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			☐ Wears Glasses/Contacts		
☐ Diabetes			☐ Cancer		
☐ Heart Condition			☐ Sickle Cell Anemia		
☐ Kidney/Bladder			☐ Bleeding Disorder		
☐ Headaches			☐ Mental Health Condition		
☐ Other, please specify					

Please indicate any allergies your child has: ☐ Medications _____ ☐ Insect stings/bites _____

☐ Food _____ ☐ Other _____

Does your child have emergency medications for allergies? ☐ Yes ☐ No

What symptoms does your child have if they have an allergic reaction to the above? ☐ Rash ☐ Hives ☐ Trouble breathing or swallowing

☐ Swelling all over ☐ Swelling at the site of the sting/bite ☐ Other _____

Name(s) of Brothers and Sisters:	DOB	School

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