THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Health Services Hall Center
PLEASE COMPLETE CARD IN FULL

EMERGENCY INFORMATION REGISTRATION CARD FOR CLINIC

Student Name	Date of Birth	Grade	Homeroom Teacher

Parent Contact 1	Home Phone

Work Phone	Cell Phone	Other Phone

Address	Zip

Parent Contact 2	Home Phone

Work Phone	Cell Phone	Other Phone

Address	Zip

Two persons authorized to assume responsibility for the student, if the parent cannot be reached.

Name	Home Phone	Cell Phone
Name	Home Phone	Cell Phone

Doctor	Phone	Hospital

Does your child have health insurance? ☐ Yes ☐ No
List student's Health Insurance Provider: ____________
If Medicaid, give Medicaid # ____________
If student does not have health insurance, see back for note on Florida Kid Care.

Name of relative in this school:

Does the student take medications? ☐ Yes ☐ No
If yes, list medications on the back of the card.

List any of your child's health problems or conditions.

☐ Vision ☐ Medication allergy: ____________
☐ Hearing ☐ Insect allergy: ____________
☐ Speech ☐ Food allergy: ____________
☐ Other allergy: ____________

Specific Health Condtiions: ____________

I authorize designated Escambia County School District personnel and PSA Healthcare School Health personnel to provide emergency care for my child and to exchange medical information as necessary to support the continuity of care of my child. By my signature below, I acknowledge the above and the receipt of the Notice of Privacy Practices contained in the Students Rights and Responsibilities Handbook.

Parent/Guardian
Signature: ____________ Date: ____________

If my child is covered by Medicaid and receives health services or therapy under an IEP, I consent for the school district to release information about my child's school based services to a billing agency and to bill Medicaid for those services each time a billable service is provided. This allows the District to receive Medicaid funding for services it provides to my child while in school. Consenting does NOT affect your family Medicaid insurance benefits or other insurance plans. There is no cost to your family. If you do not give consent, services will still be provided to your child. You have the right to refuse consent and you have the right to revoke your consent to bill Medicaid.

Parent/Guardian
Signature: ____________ Date: ____________

MEDICATIONS

Name of Medication	Dosage	Time Taken	Doctor	Reason for Medication

Florida KidCare: Child health insurance you can afford! For more information call 1-888-540-5437 or go to www.floridakidcare.org