



Manatee County School Health Services ANNUAL STUDENT MEDICAL / HEALTH INFORMATION



School _____ School Year _____ Gr _____ Teacher _____

All contact information on this form must match the official names and contact numbers given to the school

Student's Legal Last Name _____ Student's Legal First Name _____ MI _____ Birth Date _____ Age _____ Sex _____

Address/City/State/Zip _____ Home Telephone _____

Mother's Name _____ Place of Employment _____ Cell # _____ Work Telephone _____

Father's Name _____ Place of Employment _____ Cell # _____ Work Telephone _____

Additional Emergency and Clinic Contact/Pick-up List: Should my child become ill or injured during the school day and the school be unable to contact me, I hereby give the school permission to contact one or more of the following persons to pick up my child at school and care for my child during my absence. **Contact(s) should be the same name(s) as on the BioForm record in the school office.**

(1) Name _____ Relationship _____ Telephone _____ (2) Name _____ Relationship _____ Telephone _____

(3) Name _____ Relationship _____ Telephone _____ (4) Name _____ Relationship _____ Telephone _____

OTHER(1) CHILDREN _____ (2) _____
Name _____ School/Grade _____ Name _____ School/Grade _____

PHYSICIAN _____ **PHONE** _____ **DENTIST** _____ **PHONE** _____

MEDICAL PROBLEMS (check all that apply/use additional sheet to specify (if necessary))

MEDICAID Yes No

- ADHD
- Allergy Food Medicine Insects
Specify _____
Life Threatening? _____ Yes _____ No
- Describe Reaction _____

- Gastrointestinal Condition -
Specify _____
- Hearing Impairment / Hearing Aide
- Heart Disease/Murmur
Diagnosis _____

- Muscular Dystrophy
- Autism Spectrum Disorder (ASD)
- Physical Impairment
Specify _____
- Pregnancy – Due Date _____
- Psychological Disorders
Specify _____
- Scoliosis
- Sickle Cell Disease
- Speech Impairment
- Transplant _____
- Vision Impairment / Blind
Glasses / Contact Lens

- Arthritis – Specify _____
- Asthma – Date of Last Attack _____
- Cerebral Palsy
- Diabetes – Type _____
Insulin at School - Yes / No
- Epilepsy/Seizure – date of last
Seizure _____
- Other – Specify _____

- Hemophilia
- Hypertension
- Hypoglycemia
- Immuno-suppression / Cancer
- Kidney/Urologic Condition
Specify _____
- Diagnosed Migraines

A completed Medication Authorization form is required, signed by physician, for all medication administered at school, including epinephrine auto-injector, inhalers and over the counter medication. Parents must provide all medication, equipment and supplies needed at school. If your child needs a nursing procedure, or has a physical limitation or activity restriction, you must provide medical documentation to the nurse.

List medications and dosage your child takes at home _____

ADDITIONAL INFORMATION _____

In case of accident or serious illness during the school day, I request that the school contact me. In case of emergency, I hereby give the school permission for my child to be transported by Emergency Medical Services to the hospital and given the necessary treatment. I understand that I will be responsible for any and all related charges. I understand that it is the parent's/guardian's responsibility to notify the school of any changes in this information throughout the school year and complete a new medical information form each school year. This information will become part of the student's permanent school record.

THIS INFORMATION WILL BE SHARED WITH OTHER SCHOOL AND MEDICAL PERSONNEL WHO HAVE A NEED TO KNOW.

Signature: _____ Enrolling Parent/Legal Guardian _____ Date _____

Print: _____ Enrolling Parent/Legal Guardian _____ Date _____

