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 CHILDREN (1) Name | School/Grade (2) 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_____
- ☐ Arthritis – Specify_____
- ☐ Asthma – Date of Last Attack_____
- ☐ Cerebral Palsy
- ☐ Diabetes – Type_____
  Insulin at School - Yes / No
- ☐ Epilepsy/Seizure – date of last Seizure_____
- ☐ Gastrointestinal Condition - Specify_____
- ☐ Hearing Impairment / Hearing Aide
- ☐ Heart Disease/Murmur
  Diagnosis _____
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Immuno-suppression / Cancer
- ☐ Kidney/Urologic Condition
  Specify_____
- ☐ Diagnosed Migraines
- ☐ 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

Other – Specify _____

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.

MIS 41-00315. Expires 1/2022
Revised/Approved: 1/2017
Exceptional Student Education
Distribution: Parent/Guardian, School Clinic

_____
Signature: Enrolling Parent/Legal Guardian **Date**

_____
Print: Enrolling Parent/Legal Guardian **Date**

Last Name First Name M/F Grade

Date	Time In	Time Out	Problem / Intervention	Disp.	Seen By

_____ _____ _____ _____

Initials Staff Signature Initials Staff Signature

_____ _____ _____ _____

Initials Staff Signature Initials Staff Signature

SA = Stomach Ache
HA = Head Ache
TC = Telephone Call
OBS = Observation

N/V = Nausea & Vomiting
SH = Sent Home
RTC = Returned to Class
BA = Band Aid

BR = Bathroom
R/O = Rule Out
C/O = Complaint of
LS = Letter Sent
ST = Sore Throat

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Exceptional Student Education
Distribution: Parent/Guardian, School Clinic