2017-2018

OKALOOSA COUNTY SCHOOL DISTRICT
Student Intervention Services
Okaloosa Medical Card

Please print all information clearly in ink

MIS 6344
Rev. 06/2017

Student_____ _____ _____ _____/_____/_____
(Last) (First) (M.I.) (DOB-M/D/Y)

Teacher_____**Grade**_____**Car**_____**Walk**_____**Bus #** _____ (BUS NUMBER)

Student's Address_____

Student Lives with_____**Mother/Guardian's Name**_____

Home Phone_____**Cell Phone**_____**Work Phone**_____

Father/Guardian's Name_____

Home Phone_____**Cell Phone**_____**Work Phone**_____

Please list relatives or friends, who have your permission to check your child out of school, and their phone number during school hours. In the event of an emergency in which we are unable to locate the parents, emergency contact persons will be contacted. **These individuals will be authorized to act in behalf of yourself and your child.** If an extreme emergency situation occurs, we will call 911 and your child will be transported to the nearest emergency facility.

Emergency Contact Persons:

Name/Relationship: _____Phone Number: _____
Name/Relationship: _____Phone Number: _____
Name/Relationship: _____Phone Number: _____
Name/Relationship: _____Phone Number: _____

School Board Regulations require that any medication taken by students during school hours and administered by school personnel:
1) Must be accompanied by a School Board Approved Medical Form signed by a parent or legal guardian; 2) **Medication must be brought by parent /guardian in its original container properly labeled**; 3) First dosage of any new medication shall not be administered during school hours due to the possibility of an allergic reaction; and 4) Parent must provide necessary equipment and supplies needed to administer medication.

PLEASE COMPLETE BOTH SIDES.

This card serves as the primary medical history for the student.

Check any medical conditions that apply:

____ None

_____Allergy _____Bee Sting _____Food _____Other Allergies _____ADD/ADHD _____Asthma

_____Diabetes _____Gastrointestinal _____Heart _____Kidney/Bladder _____Seizures _____Other

Explain:_____

_____

Medication Currently Prescribed: **Reason:**

_____ _____

_____ _____

_____ _____

Physician's Name_____ **Office Number**_____

Permission for Emergency Treatment

In the event my child is found eligible for Exceptional Student Education services, I authorize the Okaloosa County School Board to release and exchange my child's confidential information to agencies of the state of Florida which would allow the District to Verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's individualized educational plan (IEP), and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. I understand that my child will continue to receive services referenced on his/her IEP whether or not I give consent.

I/We hereby authorize a representative of the school to obtain and give consent to whatever medical treatment the representative deems necessary whenever I or an emergency contact cannot be reached. Additionally I/We will not hold the school district or representative financially responsible for the emergency care and/or transportation for said child. Should any information on this card need to be changed, please notify the school in writing. Parents/Guardians are responsible for keeping all information on card updated.

Date_____ Parent/Guardian Signature_____