Marion County Public Schools
Developing Successful Citizens -- Every Student, Every Day

STUDENT MEDICAL INFORMATION FORM

512 SE 3RD Street, Ocala FL 34471 ▯ PO Box 670
(352) 671-7700 ▯ www.marionschools.net
FRS (800) 955-8770 ▯ (800) 955-8771 (TTY)

This form is to be completed annually by parent/guardian ONLY. Please notify school of any changes in this information throughout the school year.

STUDENT INFORMATION : *PLEASE PRINT LEGIBLY*

Student #: _____

Last Name: _____ First Name: _____ Middle Name: _____ Jr., II, etc.: _____

Birth Date: ____/____/____ Age: _____ Grade: _____ School: _____

PARENT/GUARDIAN INFORMATION:

Mother/Guardian: _____ Home Phone: _____
Last Name, First Name

Work Phone: _____ Cell Phone: _____

Father/Guardian: _____ Home Phone: _____
Last Name, First Name

Work Phone: _____ Cell Phone: _____

All parent/guardian contact information MUST be verified and updated by the parent/guardian using Skyward Family Access, if you do not have an account please contact the school office.

HEALTH CONDITIONS AND/OR NEEDS REQUIRING MEDICAL ASSISTANCE AT SCHOOL: (Check all that apply)

☐ NONE – Student has no known health condition(s) or medical need(s)

☐ ADHD/ADD
☐ Life Threatening Allergies
☐ (Specify) _____
☐ Non-Life Threatening Allergies
☐ (Specify) _____
☐ Asthma – History of Asthma ONLY ▯
☐ Autism (ASD)
☐ Bleeding Disorder
☐ Cerebral Palsy
☐ Cancer
☐ (Specify) _____
☐ Cardiac Condition(s)
☐ (Specify) _____
☐ Crohn's Disease
☐ Cystic Fibrosis
☐ Type 1 Diabetes
☐ Type 2 Diabetes
☐ Feeding Tube
☐ (Specify Type) _____
☐ Hypoglycemia
☐ Kidney Disorder
☐ (Specify) _____
☐ Lupus (SLE)
☐ Mental/Behavioral Health Disorder
☐ (Specify) _____
☐ Seizure Disorder/Epilepsy
☐ Sickle Cell Disease
☐ Spina Bifida
☐ Tracheostomy
☐ Other: _____

Medical Services needed at SCHOOL: ***(Parent/Guardian authorization & physician order required)***

_____

_____

_____

SCHOOL USE ONLY: Received by _____ Date _____ Reviewed by nurse _____ Date _____ ☐ Comments on back

I understand and agree to the following:

- ▯My child's records and information may be shared with the School Board's health care partners as needed to provide and evaluate health care services.
- ▯If my child is or becomes Medicaid eligible, reimbursable services may be billed to Medicaid and my child's information and records may be provided to Medicaid and/or the School Board's Medicaid processing agents or the School Board's health care partners. Consent for Medicaid billing may be revoked at any time and if consent is revoked, these services will be provided at no cost.
- ▯In case of emergency, my child may be transported by Emergency Medical Services to a hospital and provided treatment, and I am responsible for charges related to the transportation and medical treatment.
- ▯My child will participate in the School Health Services Program. If I wish for my child to opt out of any School Health Service, I will provide a written letter to the school principal. For more information about our School Health Services Program visit www.marionschools.net/HealthServices.

Student's Physician (Print): **Phone:**

Parent/Guardian Name (Print):

Parent/Guardian Signature: **Date:**

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