# BDS Student Emergency Information Card

The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by school staff on a need-to-know basis. **This form is required for access to all health services, as well as field trips and extra-curricular activities**. It is the parent's responsibility to provide the school with any changes or updates to your child's information.

| **Student Information** | | |
|---|---|---|
| Last | First | Middle |
| Address | | |
| School | Grade Level/Homeroom Teacher | |

| **Parent Information** | | |
|---|---|---|
| Last | First | |
| Cell Phone | Work Phone | Home Phone |

Is the student a child of an active duty military family? ☐YES ☐ NO If yes, which branch? _____

Is the student a child of a Department of Defense Employee? ☐YES ☐NO

**Medical Information**

Health Insurance YES/NO Insurance Company: _____ Policy # _____

Medicaid # _____ Tricare Sponsor ID # _____ Florida Kid Care: YES/NO

Does your child take medication? ☐ YES ☐ NO

If your child requires medication at school, all medication sent to the school must be in the original prescription container with a current date and the child's name. Before medication can be dispensed, a **"Permission to Administer Medication**" form must be completed and signed by the physician and the parent and must be on file at the school.

| Medication | Dosage | Hour(s) Given |
|---|---|---|
| | | |
| | | |
| | | |

| Does your child wear contacts/glasses? | Does your child wear hearing aid(s)? |
|---|---|
| □YES □NO | □YES □NO |

**Check all that apply to your child:**

□ Asthma If yes, uses inhaler/medication? □ Yes □ No □ Diabetes If yes, insulin dependent? □ Yes □ No

□ Seizures If yes, on medication? □ Yes □ No □ Cystic Fibrosis If yes, on medication? □ Yes □ No

Movement Limitations _____

□ Recent illness/hospitalization/surgery (describe) _____

□ Severe allergies? If checked, please specify: _____

□ Food/environmental □ Insect stings/bees □ Medicines/Drugs Other:_____ Allergies Require: □ EpiPen □ Benadryl

□ Other Medical Needs:

**Medical Information & Treatment**

By signing below, I understand and agree that certain educational health related records of my child will be shared with the School Board's health care partners (which include PanCare of Florida, Inc., & the Department of Health, Bay County) as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by the health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records. I further authorize the School Board's health care partners to contact my child's pediatrician(s) or physician(s) to obtain personal medical information as it pertains to student health services and I authorize such providers to release medical information to the School Board.

I hereby consent to my child's medical information, parental contact information, and other health information (collected from health services provided at school, including information stored electronically) being shared with emergency personnel and health department officials to address conditions of public health importance, including information to meet and to prepare for health conditions.

**By signing below, I give the School Board permission to seek emergency medical treatment in case of a serious accident or illness.** I also authorize the exchange of medical information as necessary to support the continuity of care for my child. In the event of an emergency while on a school sponsored field-trip or event, I give consent to any and all medical treatments and surgical procedures which may be deemed advisable by a qualified physician. Emergency transportation to a health care facility, as determined by paramedics, will be authorized.

In addition to the consents and releases stated above,

☐ **I DO** ☐ **I DO NOT** authorize the submission of claims to Medicare, Medicaid, or any other payer for services provided to my child by the School Board of Bay County, Florida (the "School Board") now, in the past, or in the future, until such time as I revoke this authorization in writing. I authorize the School Board to release medical, insurance, billing, or other relevant information about my child to its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as necessary to determine benefits payable for any services provided to my child by the School Board, now, in the past, or in the future. I authorize the School Board to obtain medical, insurance, and billing information about my child from any party, database, or other source that maintains such information. I understand that I may withdraw this consent at any time and that if I refuse or withdraw consent, the School Board will continue to provide all services necessary to provide a free and appropriate education. If consent is withdrawn, no information will be released after the date of withdrawal.

☐ **I DO** ☐ **I DO NOT** give consent for the Life Management Center Mobile Response Team (MRT) to conduct a screening if my child is in crisis.

**Parent Signature:** _____ **Date:** _____