



CONTACT, MEDICAL, & EMERGENCY FORM

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F R S (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

Last Name:		First Name		Middle Name:		Jr., II, etc:	
Birth Date: / /		Age:		Grade:			
Residence Address:				Apt#:	City:	State:	Zip:
Mailing Address(if different):				Apt#:	City:	State:	Zip:

PARENT/GUARDIAN INFORMATION:

Mother's/Guardian's Name:		Place of Employment:		Work Phone:	
Address (If different from home address):		Home Phone:		Cell Phone:	
Father's/Guardian's Name:		Place of Employment:		Work Phone	
Address (If different from home address):		Home Phone:		Cell Phone:	

ADDITIONAL STUDENT INFORMATION:

STUDENT LIVES WITH: (check one) <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____				
(Attach any restraining order or similar judicial pleading that prohibits parental access. If a court-adopted parenting plan is in effect, attach a copy)				
OTHER BROTHERS/SISTERS ENROLLED IN MARION COUNTY PUBLIC SCHOOLS				
Name: _____		Name: _____		Name: _____
Grade: _____		Grade: _____		Grade: _____

SPECIAL HEALTH PROBLEMS AND/OR NEEDS REQUIRING MEDICAL ASSISTANCE AT SCHOOL

<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Vision/Hearing/Speech	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other(Specify) _____
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Sickle Cell Disease or Trait	<input type="checkbox"/> Prescribed Medication (Specify) _____	
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> EpiPen	<input type="checkbox"/> Medical Procedure	<input type="checkbox"/> Allergies (Specify) _____	
Medical Services needed at SCHOOL: <i>Parent/Guardian authorization & physician order required</i> _____				

SCHOOL USE ONLY: Rcvd by _____ date _____ Reviewed by nurse _____ date _____ <input type="checkbox"/> comments on back:				

CHILD PICK-UP/EMERGENCIES: I agree that the school may release my child to the following people and provide pertinent information related to this release.

(1)Name:	Relationship:	Phone:	(2)Name:	Relationship:	Phone:
(3)Name:	Relationship:	Phone:	(4)Name:	Relationship:	Phone:

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.
- 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.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date _____

SCHOOL USE ONLY:

School Name:		Entry Date: / /		School Year: /	
Student ID #:	Grade:	Ethnicity:	Race :	Sex Code:	
Teacher Name:				Route #:	