

# CONFIDENTIAL MEDICAL INFORMATION FORM 2023 – 2024



Student's Name \_\_\_\_\_ Polk ID# \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Home phone # (1) \_\_\_\_\_ ph.#(2) \_\_\_\_\_ Bus # \_\_\_\_\_  
 MM/DD/YYYY

Physician's Name \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

<b>Parent or Guardian must complete this page, sign the back of this form, and return the form to the school.</b> Please mark the check box next to any condition or illness that applies to your child. <b>Note: For medication questions, please mark the "yes" box only if child is taking medication now.</b>	
1.	Allergy to: <input type="checkbox"/> Food: _____ Allergy to: <input type="checkbox"/> Medicine: _____ Allergy to: <input type="checkbox"/> Ants, <input type="checkbox"/> Wasps, <input type="checkbox"/> Bee stings, <input type="checkbox"/> Environmental or other. Please list: _____ Specify reaction to allergy or allergen: <input type="checkbox"/> Rash, <input type="checkbox"/> Swelling, <input type="checkbox"/> Hives, <input type="checkbox"/> Trouble Breathing, <input type="checkbox"/> Vomiting, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Other _____ <input type="checkbox"/> Takes medication for any allergies. Name medication(s): _____ Does child need a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, the school will require a Diet Modification Form from a doctor. Obtain the Diet Modification Form on-line or from the School Nutrition Manager.)
2.	<input type="checkbox"/> Asthma. History of: <input type="checkbox"/> Yes Under doctor's care now? <input type="checkbox"/> Yes <input type="checkbox"/> No List triggers: _____ <input type="checkbox"/> Takes medication for asthma. Name medication(s): _____
3.	<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (ADD/ADHD). <input type="checkbox"/> Takes medication. Name medication(s): _____
4.	<input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Diagnosed by Medical Doctor <input type="checkbox"/> Takes medication. Name medication(s) _____
5.	<input type="checkbox"/> Autoimmune Disease (Lupus, etc.) Explain: _____
6.	<input type="checkbox"/> Blood disorder <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Bleeding condition. Specify: _____
7.	<input type="checkbox"/> Cancer. Explain: _____
8.	<input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Takes medication. Name medication(s): _____
9..	<input type="checkbox"/> Diabetes. Does child require insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No Does child require insulin <u>at school</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Takes medication. Name medication(s): _____ <input type="checkbox"/> Hypoglycemia (low blood sugar). <input type="checkbox"/> Takes medication. Name medication(s) _____
10.	<input type="checkbox"/> Digestive disorders. Explain: _____
11.	<input type="checkbox"/> Head injury (serious). Explain: _____
12.	<input type="checkbox"/> Hearing problem <input type="checkbox"/> Uses hearing aid. <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear
13.	<input type="checkbox"/> Heart condition. Explain: _____ Under doctor's care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No; Any physical restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____
14.	<input type="checkbox"/> High Blood Pressure (Hypertension) <input type="checkbox"/> Takes medication. Name medication(s) _____
15.	<input type="checkbox"/> Kidney or bladder disorder. Explain: _____ <input type="checkbox"/> Requires catheterization. Explain or type of catheterization: _____
16.	<input type="checkbox"/> Mental Health Condition. Specify: _____ <input type="checkbox"/> Takes medication. Name medication(s) _____
17.	<input type="checkbox"/> Migraines. Under doctor's care for migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No; <input type="checkbox"/> Takes medication. Name medication(s) _____
18.	<input type="checkbox"/> Muscle/bone/mobility disorder. Explain: _____
19.	<input type="checkbox"/> Seizure Disorder. Type of seizure(s): _____ How long ago was the last one? _____ <input type="checkbox"/> Takes medication. Name medication(s) _____
20.	<input type="checkbox"/> Vision problems. Explain: _____ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
21.	<input type="checkbox"/> Other medical condition not listed. Explain: _____ <input type="checkbox"/> Other medications taken not listed above: _____
22.	<input type="checkbox"/> My child does <u>not</u> have any of the listed conditions or illnesses.

Additional comments or other health information:

\_\_\_\_\_

\_\_\_\_\_

# Parent Consent for School Health Services

## School Year 2023 – 2024

Student's Name \_\_\_\_\_ Polk ID# \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

The Florida Department of Education and the Florida Department of Health work in cooperation to coordinate the School Health Services Program as mandated in Florida Statute sections 381.0056, 281.0057, and 402.3026. Pursuant to Florida Statute 1001.42: A parent/guardian **MUST** opt-in yearly for their child to receive school Health Services/Clinic Services. Please indicate if you want your student to be able to receive the services indicated below. Circle "yes" or "no".

YES	NO	<p><b>I want my child to be able to access care in the clinic due to illness or injury. School health/clinic services may include: first aid, emergency care *, health appraisals, nursing assessment, health counseling, referral and follow-up, health promotion, disease and injury prevention, basic health education provided in the clinic, and health consultations.</b></p> <p>If "NO", the student will NOT receive health/clinic services as outlined above, including, but not limited to, temperature checks, first aid, etc.</p>
YES	NO	<p><b>I want my child to participate in individual student screenings related to learning, behavior and/or social emotional well-being as needed by the school problem-solving team to ensure proper instruction and intervention in these areas. This may also include an individual vision and/or hearing screening to rule out vision difficulties affecting learning.</b></p>

\* There is not an option to withhold/decline consent for emergency care. In emergency situations, school personnel will contact Emergency Medical Services and provide emergency care until EMS arrives. Once EMS arrives, they will take whatever action is deemed necessary for the health and safety of your child. Parents are financially responsible for any emergency care and/or transportation your child needs.

**This consent DOES NOT AUTHORIZE invasive screening or procedures (COVID-19 testing, blood draw, vaccinations, etc.), preventative health care, medication administration, mental health counseling, therapy (physical therapy, occupational therapy, etc.) or other services that require specific parental direction and consent (administration of medication, medical procedures, medical management of chronic health conditions, etc.)**

For your child to receive any medication or medical treatment at school, you must consent to health services/clinic visits and provide a new Authorization for Medication/Treatment signed by you and your child's doctor each school year. All medications must be brought to school by an adult. All medications and/or treatment, equipment or supplies must be supplied by the parent/guardian.

You are also required to complete the Emergency and Contact Information Form and update information annually or any time the information changes. School personnel will contact you to pick up your child if he/she is unable to remain at school due to illness or accident. If school personnel are unable to reach you, one of the adults listed on the Emergency and Contact Information Form designated to pick up your child will be contacted.

**NOTICE: The following state mandated health screenings are provided: vision screening in grades PreK, K, 1, 3, 6; hearing screening in grades PreK, K, 1, 6; growth and development/Body Mass Index (BMI) screening in grades PreK, 1, 3, 6; blood pressure screening for Head Start PreK; and scoliosis screening in grade 6. If you do not want your child to participate in any of the screenings above, please complete the School Health Screening Opt-Out Form available at your child's school. You may also access the form from the district's website (<https://polkschoolsfl.com/policiesandforms>). The opt-out form must be completed and submitted each school year that you do not want your child to participate in the mandatory health screenings.**

Polk County Public Schools will only share student medical information from education records in accordance with law. It may be necessary to share some information about your child with the School Board's health care partners to provide and evaluate health services or obtain emergency medical treatment. Your child's education records may also be shared with school officials who have a legitimate educational purpose for accessing such treatment records. Therefore, it is your responsibility to notify the school of any changes in the information recorded on this form.

**I certify that I consent to or decline Health Services/Clinic Services as indicated above, that the information on this Medical Information Form is accurate, and that I understand the school keeps all medical information and records in accordance with Florida law.**

Date: \_\_\_\_\_ Enrolling Parent/Guardian Signature: \_\_\_\_\_

Print Enrolling Parent/Guardian Name: \_\_\_\_\_