

CONFIDENTIAL MEDICAL INFORMATION FORM 2019-2020



Student's Name _____ Polk ID#5300- _____ Grade _____ Teacher _____

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

<p>Parent or Guardian must complete this page, sign the back of this form, and return the form to the school. Please mark the check box next to any condition or illness that applies to your child. Note: for medication questions, please mark the "yes" box only if child is taking medication now.</p>	
1.	<p>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.)</p>
2.	<p><input type="checkbox"/> Asthma. Diagnosed at age: _____ 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): _____</p>
3.	<p><input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (ADD/ADHD). <input type="checkbox"/> Takes medication. Name medication(s): _____</p>
4.	<p><input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Diagnosed by Medical Doctor <input type="checkbox"/> Takes medication. Name medication(s) _____</p>
5.	<p><input type="checkbox"/> Autoimmune Disease (Lupus, etc.) Explain: _____</p>
6.	<p><input type="checkbox"/> Blood disorder <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Bleeding condition. Specify: _____</p>
7.	<p><input type="checkbox"/> Cancer. Explain: _____</p>
8.	<p><input type="checkbox"/> Cardiac/ 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: _____</p>
9.	<p><input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Takes medication. Name medication(s): _____</p>
10.	<p><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) _____</p>
11.	<p><input type="checkbox"/> Digestive disorders. Explain: _____</p>
12.	<p><input type="checkbox"/> Head injury (serious). Explain: _____</p>
13.	<p><input type="checkbox"/> Hearing problem <input type="checkbox"/> Uses hearing aid. <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear</p>
14.	<p><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: _____</p>
15.	<p><input type="checkbox"/> High Blood Pressure (Hypertension) <input type="checkbox"/> Takes medication. Name medication(s) _____</p>
16.	<p><input type="checkbox"/> Kidney or bladder disorder. Explain: _____ <input type="checkbox"/> Requires catheterization. Explain or type of catheterization: _____</p>
17.	<p><input type="checkbox"/> Mental Health Condition. <input type="checkbox"/> Takes medication. Name medication(s) _____</p>
18.	<p><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) _____</p>
19.	<p><input type="checkbox"/> Muscle/bone/mobility disorder. Explain: _____</p>
20.	<p><input type="checkbox"/> Seizure Disorder. Type of seizure(s): _____ How long ago was the last one? _____ <input type="checkbox"/> Takes medication. Name medication(s) _____</p>
21.	<p><input type="checkbox"/> Vision problems. Explain: _____ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts</p>
22.	<p><input type="checkbox"/> Other medical condition not listed. Explain: _____ <input type="checkbox"/> Other medications taken not listed above: _____</p>
23.	<p><input type="checkbox"/> My child does <u>not</u> have any of the listed conditions or illnesses.</p>

NOTE: Use the "Comments" section on the back of this page for additional explanations or health information.

School: _____

Grade: _____

Student's Full Name: _____

Date of Birth: _____

Additional comments or other health information:

Does your student have insurance coverage? (private, Medicaid, etc.) Yes No

If you answered "no," to the above question, would you like a healthcare advocate to personally contact you about KidCare, a free or low-cost health insurance option provided through the State of Florida? Yes No

What is the best phone number for the healthcare advocate to contact you? _____

I certify that the information I have provided above on this Medical Information Form is accurate, true and correct. I understand the school keeps all medical information and records in accordance with law.

Date: _____

Enrolling Parent/Guardian Signature: _____

Print Enrolling Parent/Guardian Name: _____

NOTIFICATION OF HEALTH SERVICES PROGRAMS

The Health Services Program in Polk County Schools includes health appraisal, monitoring for communicable diseases and emergency care. It also includes the following state mandated health screenings: vision screening in grades PreK, K, 1, 3, 6, and summer programs; 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. In addition, individual vision and/or hearing screening may be conducted at any grade level to rule out vision and/or hearing difficulties. If you do not want your child to participate in the mandated screenings, please complete the Mandated Health Screening Opt-out Form available at your child's school. You may also access the form from the district's website (www.polk-fl.net/parents/formsanddocuments/default.htm). The opt-out form must be completed and submitted each school year that you do not want your child screened.

In order for your child to receive any medication or medical treatment at school, you must 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 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. School personnel will contact Emergency Medical Services in an emergency situation to 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.

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 in order 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.

The School Board of Polk County, Florida, prohibits any and all forms of discrimination and harassment based on race, color, sex, religion, national origin, marital status, age, homelessness, or disability or other basis prohibited by law in any of its programs, services, activities or employment. To file concerns, you may contact the Office of Equity & Compliance in the Human Resource Services Division at (863) 534-0513.

If you require any type of accommodation to complete the application process due to a disability, please call the Human Resource Services Division at (863) 534-0781. If you are deaf or hard of hearing, please contact the Polk County School District by calling Florida Relay Service at 1-800-955-8771.

The Mission of Polk County Public Schools is to provide a high quality education for all students.