

CONFIDENTIAL MEDICAL INFORMATION FORM 2022 – 2023



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

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

Physician's Name _____ Physician's Phone Number _____

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.	
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. 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): _____
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 2022 – 2023

Due to the Parental Rights in Education legislation, parents/guardians now must provide written consent for their child to participate in school health services, including clinic visits.

This consent must be renewed yearly. Please indicate if you want your student to participate in the Health Services below. Circle 'yes' or 'no'.

YES	NO	I want my child to participate in school health/clinic services, which 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, and health consultations. If "NO", the student will not receive clinic services as outlined above, including, but not limited to, temperature checks, applying band aids, etc.
YES	NO	I want my child to participate in vision screening in mandated grades* and at any grade level if needed to rule out vision difficulties affecting learning.
YES	NO	I want my child to participate in hearing screening in mandated grades* and if needed individually to rule out hearing difficulties affecting learning.
YES	NO	I want my child to participate in Height/Weight/Body Mass Index screening in mandated grades*
YES	NO	I want my child to participate in Scoliosis screening in mandated grades* (6 th grade only)
YES	NO	I want my child to participate in blood pressure screening in mandated grades levels* (Head Start PreK only)
YES	NO	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.

* 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.

NOTE: 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.

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.

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 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 law.

Date: _____ Print Student Name: _____ Student Number: _____

Enrolling Parent/Guardian Signature: _____

Print Enrolling Parent/Guardian Name: _____