AV 101-15

RETURN THIS FORM TO SCHOOL

ANDERSON SCHOOL DISTRICT FIVE

EMERGENCY MEDICAL INFORMATION

Student's Name: _____ Grade: _____ Teacher: _____

Last First Middle

Sex: ☐ Male ☐ Female * Social Security Number: _____ Date of Birth: _____

*You are not required to provide your child's Social Security number to District Five. If you choose not to provide a Social Security number, a state-issued identification number will be assigned to your child.

*Home Phone Number: _____ *Mom's Cell Number: _____ *Dad's Cell Number: _____

*I DO NOT want the phone numbers above to be included in District Five's automated Emergency Notification System. In conjunction with Anderson County Emergency Services, the automated system will be used to notify families of school or local emergencies. *Initial to opt out* _____

	Mother's Information	Father's Information
Name of Parents		
Legal Guardian(if not parent)		
Home Address		
Email Address		
Place of Employment		
Work Phone Number		
Work Hours		

With whom does the child reside? (Check one) ☐ Mother ☐ Father ☐ Both Mother and Father ☐ Other _____

*If parents are separated or divorced, can school contact either parent, if needed, to pick student up and/or discuss medical issues?

☐ Yes ☐ No If no, custody papers must be on file in the office.

Transportation to School: ☐ Car ☐ Bus # _____ Transportation from School: ☐ Car ☐ Daycare ☐ Bus # _____

Persons (in addition to parents/guardians) to contact in case of student needs to be picked up from school.

LIST ONLY PEOPLE WHO CAN PROVIDE TRANSPORTATION FOR YOUR CHILD AND WHO YOU WILL ALLOW TO SIGN YOUR CHILD OUT OF SCHOOL. Your home/work/cell numbers will be called first in any emergency. **PLEASE KEEP ALL NAMES AND NUMBERS UP TO DATE.**

Name	Relationship to Student	Phone Number(s)
1.		
2.		
3.		
4.		

List any other children in the household who attend schools in Anderson School District Five:

Child's Name	School

Continued on back →

Does your child have a Medical Doctor? ☐ Yes ☐ No If yes, Doctor's Name: _____ Phone #: _____

Is your child covered by Health Insurance/Medicaid? ☐ Yes ☐ No Medicaid Number, if applicable _____

Does your child have a severe allergy? ☐ Yes ☐ No **If yes, please complete area below and see school nurse.**

Allergy to Medication(s): _____

Allergy to food(s): _____

Allergy to insect(s): _____

Seasonal Allergies: _____ Other Allergies: _____

Does your child have any other medical problems: ☐ Yes ☐ No If yes, please list and state any treatment and/or medications:

_____

RELEASE OF INFORMATION & REIMBURSEMENT FOR NURSING/MEDICAID SERVICES

By my signature below, I consent for the Anderson School District Five to:

- Provide health-related services to my child; release and exchange the following information from my child's record to the Department of Health and Human Services (Medicaid Agency) or my child's health insurance carrier for the purpose of billing for the health related services provided to my child—information about the service provided, my child's name, date of birth, Medicaid or health insurance number, gender, and my contact information; bill the Medicaid Agency and other insurance carriers for the health-related services; and receive payment from the Medicaid Agency and other insurance carriers for the health-related services that the District provides to my child.

I understand that:

- Medicaid reimbursement for health-related services provided by the District will not affect any other Medicaid services for which my child is eligible.
- The District will continue to provide required health-related services for my child at no cost to me even if I refuse to allow billing for services.
- Granting consent is voluntary on my part and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).
- The District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of health related services.

Student's Name	Date of Birth	Medicaid Number

Signature of Parent/Guardian	Date

CONSENT FOR TREATMENT, EMERGENCY AUTHORIZATION AND RELEASE OF INFORMATION

I, the undersigned, do hereby consent for the Anderson School District Five to provide health-related services to my child. I authorize officials of **Anderson School District Five** to contact directly the persons named on this form, and do authorize the Health Care Provider to render such treatment as may be deemed necessary in an emergency, for the health of said child. I authorize the release of any information on this form to medical personnel to insure prompt treatment of my child.

In the event physician(s), other persons named on this form, or parents cannot be contacted, the school officials are authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I understand that information on this form is confidential and will only be shared with those who have a medical need to know. I will not hold the district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent/Guardian	Date