CONFIDENTIAL MEDICAL INFORMATION FORM 2024 – 2025

POLK COUNTY PUBLIC SCHOOLS
STUDENTS FIRST

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**_____

	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**: ☐ Food:_____ **Allergy to:** ☐ Medicine:_____ **Allergy to:** ☐ Ants, ☐ Wasps, ☐ Bee stings, ☐ Environmental or other. Please list: _____ **Specify reaction to allergy or allergen:** ☐Rash, ☐Swelling, ☐Hives, ☐Trouble Breathing, ☐Vomiting, ☐Diarrhea, ☐ Other_____ ☐ **Takes medication for any allergies.** Name medication(s)**:**_____ **Does child need a special diet?** ☐ Yes ☐ 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.	☐ **Asthma. History of:** ☐ **Yes Under doctor's care now?** ☐ **Yes** ☐ **No List triggers:** _____ ☐**Takes medication for asthma**. Name medication(s):_____
3.	☐ **Attention Deficit/Hyperactivity Disorder** (ADD/ADHD). ☐ **Takes medication**. Name medication(s):_____
4.	☐ **Autism Spectrum Disorder** ☐ **Diagnosed by Medical Doctor** ☐ **Takes medication**. Name medication(s) _____
5.	☐ **Autoimmune Disease (Lupus, etc.) Explain:** _____
6.	☐ **Blood disorder** ☐ **Sickle cell anemia** ☐ **Bleeding condition.** Specify: _____
7.	☐ **Cancer.** Explain:_____
8.	☐ **Cystic Fibrosis** ☐ **Takes medication.** Name medication(s):_____
9..	☐ **Diabetes. Does child require insulin?** ☐ **Yes** ☐ **No Does child require insulin at school?** ☐ **Yes** ☐ **No** ☐ **Takes medication.** Name medication(s):_____ ☐ **Hypoglycemia (low blood sugar).** ☐ **Takes medication.** Name medication(s)_____
10.	☐ **Digestive disorders.** Explain:_____
11.	☐ **Head injury (serious).** Explain:_____
12.	☐ **Hearing** problem ☐ **Uses hearing aid.** ☐ **Right ear** ☐ **Left ear**
13.	☐ **Heart condition.** Explain: _____ **Under doctor's care for this condition?** ☐ Yes ☐ No; **Any physical restrictions?** ☐ Yes ☐ No If yes, explain:_____
14.	☐ **High Blood Pressure (Hypertension)** ☐ **Takes medication.** Name medication(s)_____
15.	☐ **Kidney or bladder disorder.** Explain: _____ ☐ **Requires catheterization. Explain or type of catheterization:** _____
16.	☐ **Mental Health Condition.** Specify: _____☐ **Takes medication.** Name medication(s)_____
17.	☐ **Migraines.** Under doctor's care for migraines? ☐ Yes ☐ No; ☐ **Takes medication.** Name medication(s)_____
18.	☐ **Muscle/bone/mobility disorder.** Explain:_____
19.	☐ **Seizure Disorder. Type of seizure(s):**_____ **How long ago was the last one?** _____ ☐ **Takes medication**. Name medication(s)_____
20.	☐ **Vision** problems. Explain:_____ ☐ Glasses ☐ Contacts
21.	☐ **Other medical condition not listed.** Explain:_____ ☐ Other **medications** taken not listed above:_____
22.	☐ **My child does not have any of the listed conditions or illnesses.**

Additional comments or other health information:

_____

_____

Parent Consent for School Health Services
School Year 2024 – 2025

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	**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.** If "NO", the student will NOT receive health/clinic services as outlined above, including, but not limited to, temperature checks, first aid, etc.
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. This may also include an individual vision and/or hearing screening to rule out vision difficulties affecting learning.**

* 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:_____