SY 2023-2024

OKALOOSA COUNTY SCHOOL DISTRICT
Student Intervention Services
Student Medical Information & Parent Consent
Please print all information clearly in ink

MIS 6344
REV. 06/15/2023

Student_____ _____ _____ _____/_____/_____
(Last) (First) (M.I.) (DOB-M/D/Y)

School _____**Grade** _____

Student's Address_____

Mother/Guardian's Name_____

Home Phone _____**Cell Phone** _____**Work Phone**_____

Father/Guardian's Name_____

Home Phone _____**Cell Phone** _____**Work Phone**_____

Primary Care Physician _____ **Specialist** _____
(Name and office number) **(Name and office number)**

Parent / Guardian Email Address_____

Emergency Contact Persons:
Please list relatives or friends, who have your permission to check your child out of school, and their phone number during school hours. In the event of an emergency in which we are unable to locate the parents, emergency contact persons will be contacted. **These individuals will be authorized to act on behalf of yourself and your child.** If an extreme emergency situation occurs, we will call 911 and your child will be transported to the nearest emergency facility. The student's parent / guardian will be financially responsible for the cost of student's emergency transport.

Name/Relationship: _____Phone Number: _____

Name/Relationship: _____Phone Number: _____

Does your child have any medical conditions the school should be aware of? _____No _____ Yes, if yes, give diagnosis and explain:

_____

Does your child have any food allergies and/ or food intolerances? ____ No ____Yes, if yes explain:

_____

***If your child requires special diet accommodations, medical documentation will be required. ***

Medication Currently Prescribed: **Reason/use for medication:**

_____ _____

_____ _____

_____ _____

School Board Policy requires that any medication taken by students during school hours and administered by school personnel:
1) Must be accompanied by a Dispersion of Medication form (MIS 5163) signed by a parent or legal guardian; 2) **Medication must be brought by parent / guardian in its original container properly labeled**; 3) First dosage of any new medication shall not be administered during school hours due to the possibility of an allergic reaction; and 4) Parent must provide necessary equipment and supplies needed to administer medication.

PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT

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PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES

The School Health Services Plan for the Okaloosa County School District, as required in Section 381.0056, Florida Statutes, helps to promote health and wellness for children to enhance their learning. The Okaloosa County School District has contracted with Aveanna Healthcare to assist in providing school health services for all our public schools. Your child's school will be staffed with a health technician or licensed practical nurse who is supervised by a registered nurse. All student health information is kept confidential and is only shared with those staff members who have a legitimate need to know this information to provide for the health and safety of your child.

Please indicate if you want your child to participate in school health room services by circling "Yes" or "No" below.

Yes **No** I consent for my child to receive basic first aid services and care from the school clinic staff.

*** If no response is circled or "No" is circled, your child will not be seen in the school clinic and you will be called to respond to the need at school. ***

In the event of an accident or serious illness, you will be contacted by the school. If the school is unable to reach you, the school will contact the emergency contacts on the previous page and will take whatever actions are necessary to provide emergent care and treatment for your child, and exchange medical information with the emergency provider as necessary to support the continuity of care for your child.

Florida Statute 381.0056(4)(a), mandates regular health screenings for public school students. The screenings include Vision, Kg, 1st, 3rd, and 6th, and new Florida public school students through 5th grade; Hearing – Kg, 1st & 6th, and new Florida public school students through 5th grade. Height and Weight (BMI) – 1st, 3rd, & 6th and Scoliosis - 6th grade only. Parents will be notified of problems identified through the screening process.

Please indicate if you want your child to participate in these screenings by circling "Yes" or "No" below.

Yes **No** I consent for my child to participate in the above appropriate grade level screening.

My signature indicates my parental consent, understanding, and agreement.

_____ _____ _____
PRINT – PARENT / GUARDIAN SIGNATURE – PARENT / GUARDIAN DATE

MEDICAID BILLING CONSENT

FOR STUDENTS COVERED UNDER STATE MEDICAID PROGRAMS ONLY

I understand and give my consent to the school district to share information about my child with the State Medicaid Agency (State of Florida Agency for Health Care Administration), its fiscal agent, and the school district's Medicaid billing agent or billing facilitator for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child. I understand that I may withdraw this consent to release information for Medicaid reimbursement at any time. I understand that if I refuse to give my consent or withdraw this consent, the school district will continue to provide all required services necessary for my student to receive an appropriate education at no charge to my child in accordance with 34CFR§300.154(d)(2)(v)(D) or other services provided outside of any IEP. If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.

My signature indicates my parental consent, understanding, and agreement.

_____ _____ _____
PRINT – PARENT / GUARDIAN SIGNATURE – PARENT / GUARDIAN DATE

The above consent remains in effect until the parent / guardian submits a new Student Medical Information / Consent Form or the following school year.