Columbia County Schools
Student Medical Record 2018-2019

Student Legal Name (last, first, middle) Suffix (Jr., Sr., II, III, IV, V)	**Date of Birth** (mm/dd/yyyy)	**Gender :** [ ] Male [ ] Female

Check below any current health condition that may require attention during the school day.

[ ] Allergies (be specific)
- [ ] Food(s) _____
- [ ] Medication(s) _____
- [ ] Other _____
- [ ] Does your child require an Epi-pen or other medication for allergic reactions [ ] YES [ ] NO

[ ] Asthma
- [ ] inhaler or Nebulizer treatments [ ] YES [ ] NO

[ ] Seizures
- [ ] Diastat or other medications [ ] YES [ ] NO

[ ] Diabetes
- [ ] Insulin or other medications [ ] YES [ ] NO

[ ] ADHD/ADD

[ ] Other Mental Health disabilities: _____

The student has a current or previous referral for mental health services [ ] YES [ ] NO If YES, where? _____

[ ] Heart problems (be specific) _____

[ ] Physical disability (be specific) _____

[ ] Hemophilia

[ ] Sickle Cell Anemia

[ ] Cystic Fibrosis

[ ] Vision problems (be specific) _____
- [ ] Glasses [ ] Contacts

[ ] Hearing problems
- [ ] Hearing aid(s)

[ ] G-tube Feeding

[ ] Urinary Catheterization

[ ] Other (be specific) _____

List all medications and doses your child receives: _____

_____

****All medications administered at school require a doctor's note, parent permission, and must be brought to school by the parent/guardian ONLY. ****

Primary Doctor Name and Phone#	Other Doctor Name and Phone #
Dentist/Ortho Name and Phone #	
Insurance Company & Number	School Insurance [ ] YES [ ] NO
Medicaid Number:	Hospital Preference:

Parent Notice

Based on Florida Law Section 381.0056, the following Health Screenings are required: Vision – K,1,3,6; Hearing – K,1,6; Height/Weight (BMI) – 1,3,6; Scoliosis -6 (also new Florida enrollees and referrals).

Permission for my child's participation in Health Screenings and school related surveys. **Please circle:** YES NO

In the event of a serious accident or illness, the school will contact the parent/guardian. If unable to make contact, the school will contact EMS and make necessary arrangements for immediate transportation and treatment. Payment of fees will be assumed by the parent/guardian.

Signature: _____ Date _____
(Parent, Guardian)

SCHOOL NURSE USE ONLY

[ ] Immunization received
[ ] Physical received

Teacher/Homeroom: _____
Grade: _____

CCSD # 1857