Marion County Public Schools
Where Every Child Can Learn

CONTACT, MEDICAL, & EMERGENCY FORM

512 SE 3RD STREET OCALA, FL 34471 • PO Box 670
(352) 671-7700 • (352) 671-7788
www.marion.k12.fl.us
F R S (800) 955-8770 • (800) 955-8771 (TTY)

This form is to be completed annually by parent/guardian ONLY. Please notify school of any changes in this information throughout the school year.

STUDENT INFORMATION: *PLEASE PRINT LEGIBLY*

Last Name:	First Name	Middle Name:	Jr., II, etc:
Birth Date: / /	Age:	Grade:	

Residence Address:	Apt#:	City:	State:	Zip:
Mailing Address(if different):	Apt#:	City:	State:	Zip:

PARENT/GUARDIAN INFORMATION:

Mother's/Guardian's Name:	Place of Employment:	Work Phone:
Address (If different from home address):	Home Phone:	Cell Phone:
Father's/Guardian's Name:	Place of Employment:	Work Phone
Address (If different from home address):	Home Phone:	Cell Phone:

ADDITIONAL STUDENT INFORMATION:

STUDENT LIVES WITH: (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

(Attach any restraining order or similar judicial pleading that prohibits parental access. If a court-adopted parenting plan is in effect, attach a copy)

OTHER BROTHERS/SISTERS ENROLLED IN MARION COUNTY PUBLIC SCHOOLS

Name: _____ Grade: _____	Name: _____ Grade: _____	Name: _____ Grade: _____

SPECIAL MEDICAL PROBLEMS: (check all that apply / use line below to specify if necessary)

☐Allergies (Specify) ☐Asthma (specify) ☐Vision/Hearing/Speech ☐Diabetes ☐Hemophilia
☐Seizure Disorder(Specify) ☐Cystic Fibrosis ☐Sickle Cell Disease ☐Other (Specify)

_____

SPECIAL NEEDS: (Requires physician's orders and school authorization forms)

☐Diabetes Management ☐Inhaler ☐EpiPen ☐Prescribed Medication
☐Medical Procedure ☐Seizure Disorder ☐Other (Specify)

_____

SCHOOL USE ONLY

Received by: _____
School Personnel Date

Reviewed by: _____
Nurse Date

CHILD PICK-UP/EMERGENCIES: I agree that the school may release my child to the following people and provide pertinent information related to this release.

(1)Name:	Relationship:	Phone:	(2)Name:	Relationship:	Phone:
(3)Name:	Relationship:	Phone:	(4)Name:	Relationship:	Phone:

I understand and agree to the following:
- My child's records and information may be shared with the School Board's health care partners as needed to provide and evaluate health care services.
- If my child is or becomes Medicaid eligible, reimbursable services may be billed to Medicaid and my child's information and records may be provided to Medicaid and/or the School Board's medicaid processing agents or the School Board's health care partners.
- In case of emergency, my child may be transported by Emergency Medical Services to a hospital and provided treatment, and I am responsible for charges related to the transportation and medical treatment.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date** _____

SCHOOL USE ONLY:

School Name:	Entry Date: / /	School Year : /		
Student ID #:	Grade:	Ethnicity:	Race :	Sex Code:
Teacher Name:				Route #: