CONFIDENTIAL MEDICAL INFORMATION FORM 2021-2022

POLK STATE
Lakeland Gateway to College
Collegiate High School

Student's Name_____ **Polk ID#5300-**_____ **Grade** _____ **Teacher**_____

Birth Date_____ **Sex**_____ **Home phone # (1)** _____**ph.#(2)** _____ **Bus #** _____
MM/DD/YYYY

	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. Diagnosed at age: _____ 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.** ☐ **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.**

NOTE: Use the "Comments" section on the back of this page for additional explanations or health information.

School: _____ **Grade:** _____

Student's Full Name: _____ **Date of Birth:** _____

Physician's Name: _____ **Physician's Phone Number:** _____

Additional comments or other health information:

_____

_____

_____

_____

Does your student have insurance coverage? (private, Medicaid, etc.) ☐ Yes ☐ No

If you answered "no," to the above question, would you like a healthcare advocate to personally contact you about KidCare, a free or low-cost health insurance option provided through the State of Florida? ☐ Yes ☐ No

What is the best phone number for the healthcare advocate to contact you? _____

I certify that the information I have provided above on this Medical Information Form is accurate, true and correct. I understand the school keeps all medical information and records in accordance with law.

Date: _____ Enrolling Parent/Guardian Signature: _____

Print Enrolling Parent/Guardian Name: _____

NOTIFICATION OF HEALTH SERVICES PROGRAMS

The Health Services Program in Polk County Schools includes health appraisal, monitoring for communicable diseases and emergency care. It also includes the following state mandated health screenings: vision screening in grades PreK, K, 1, 3, 6, and summer programs; 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. Individual vision and/or hearing screening may be conducted at any grade level to rule out vision and/or hearing difficulties. In addition, individual student screenings related to learning, behavior, and/or social-emotional well-being may be completed as needed by the school problem solving team to ensure proper instruction and intervention in these areas. If you do not want your child to participate in any of the screenings above, please complete the School 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 screened.

In order for your child to receive any medication or medical treatment at school, you must 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 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. School personnel will contact Emergency Medical Services in an emergency situation to 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.

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 in order 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.

The School Board of Polk County, Florida, prohibits any and all forms of discrimination and harassment based on race, color, sex, religion, national origin, marital status, age, homelessness, or disability or other basis prohibited by law in any of its programs, services, activities or employment. To file concerns, you may contact the Office of Equity & Compliance in the Human Resource Services Division at (863) 534-0513.

If you require any type of accommodation to complete the application process due to a disability, please call the Human Resource Services Division at (863) 534-0781. If you are deaf or hard of hearing, please contact the Polk County School District by calling Florida Relay Service at 1-800-955-8771.