Pinellas County Schools
STUDENT CLINIC CARD & RELEASE FORM

☐ Medications given at school ☐ Health Care Plan on File ☐ Student has IEP ☐ 504 Plan

_____ Teacher

_____ School

Instructions: This form must be completed by parent and returned to school for each student. **PLEASE PRINT**

Students legal name (Last, First, Middle)			Student Nickname	
☐ Male ☐ Female	☐ White ☐ Hispanic ☐ Indian ☐ Black ☐ Asian ☐ Multiracial	Date of birth	Grade	Name of brothers, sisters at this school
Address - street number & name, City, ZIP Apt #				Home phone number
Mother's name/legal guardian (circle one)	Cell phone	Home phone Work phone	Work/Home E-mail	**Student Photo**
Father's name/legal guardian (circle one)	Cell phone	Home phone Work phone	Work/Home E-mail	
Stepparent's name (if applicable)	Cell phone	Home phone Work phone	Work/home E-mail	
Name(s) of persons(s) who will be responsible if parent cannot be reached and who is/are authorized to remove child from school during school day without further parental consent: 1.		Relationship	Cell phone	Home phone Work phone
2.			Cell phone	Home phone Work phone
Physician's name			Preferred hospital	Date last physical exam
Dentist name			Telephone #	Date Last Dental visit
Health problems - Please list any health problems that the school needs to be aware of.				
Medications - Is your child currently taking any medications (at home or in school)? ☐ Yes ☐ No Please List				
Allergies - List any your child may have ☐ mild ☐ severe				

Is there any court order restricting access to the student and/or student records? ☐ Yes ☐ No
If yes, provide the school with a certified copy.

I give my permission for my child's stepparent to have access to student records and to sign forms related to my child.
☐ Yes ☐ No

In case of accident or serious illness, the school will contact the parent. If the school is unable to contact the parent or person designated above, the school will contact the physician or dentist or will make necessary arrangements for immediate treatment.

Payment of the fees will be assumed by parent/guardian.

I have reviewed and understand the conditions of the Student Clinic Card.

___ **I authorize** ___ **I do not authorize**

the School District of Pinellas, Florida, to release and exchange my child's confidential information to agencies of the State of Florida which would allow Pinellas Schools to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's individual educational plan (IEP) and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. **I understand that my child will continue to receive services referenced on his/her IEP whether or not I give consent.**

_____ Signature of Parent/Guardian

_____ Date

Warehouse No. 98318

Date	Time In	Time Out	Reason for Visit to Clinic	1 = RTC 2 = Home 3 = 911	Initial

SIGNATURE VERIFICATION

Print Name	Initial	Signature	Print Name	Initial	Signature

Warehouse No. 98318