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 ☐ Black ☐ Hispanic ☐ Asian ☐ Indian ☐ 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 mypermission 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.

ALSO PLEASE COMPLETE THIS INDENTED SECTION IF YOU HAVE AN ESE STUDENT OR ARE ELIGIBLE FOR FREE OR REDUCED LUNCH

___ I authorize ____ I do not authorize

the School District of Pinellas County, Florida, to release and exchange my child's confidential information to agencies of the State of Florida which would allow Pinellas County Schools to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's plan (IEP, 504 plan, FBA, PBIP, Health Plan etc.) and receive Medicaid reimbursement for services it provides to my child while at school. I understand that my child will continue to receive services referenced on his/her IEP, 504 plan, FBA, PBIP, Health Plan etc. whether or not I give consent, and that I may revoke this consent at any time in writing.

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