STUDENT CLINIC CARD  & RELEASE FORM	Medications given at schoo	□ Health C I Plan on Fi		tudent	)4 Plan	Teacher	
structions: This form must be complete	d by parent and ret	umed to school	for each stu	dent. PLEASE F	PRINT	School	·
Students legal name (Last, First, Middle	)		Stude	ent Nickname	,	4	
Name of brothers, sisters at this school		□ <sub>Male</sub>	White Hispani	Black C Asian Multiracial	Date o birth	Г	Grade
Address - street number & name, City, 2	ZIP .	Apt#		· · ·		Home phone numb	er
Mother's name/legal guardian	Cell phone	Home ph	ODE .	Work/Home E-	mail	· .	
circle one) .	Cell priorie	Work pho		WORNTOINE L-IIIaii			
Father's name/legal guardian circle one)	Cell phone	Home ph Work pho		Work/Home E-mail		Student Photo	
Stepparent's name (if applicable)	Cell phone	Home ph	Home phone		Work/home E-mail		
		Work phone					
Name(s) of persons(s) who will be resp reached and who is/are authorized to re during school day without further paren 1.	Cell phone	Cell phone		Home phone Work phone			
	Cell phone	Cell phone		Home phone			
2. Physician's name		Telephone	#	Preferred hospital		Work phone  Date last physical exam	
·		<u> </u>		<u> </u>		iail	
Dentist name				Telephone #		Date Last Dental visit	
Health problems - Please list any healt	h problems that the	school needs t	to be aware o	of.			
Medications - Is your child currently tak	ing any medication	s (at home or in	school)? [	] Yes □ No	Please	List	
Allergies - List any your child may have	mild severe			· · · · · · · · · · · · · · · · · · ·			
there any court order restricting a yes, provide the school with a cert		lent and/or stu	ident record	ls? ☐ Yes	□.No		
give my permission for my child's s	stepparent to hav	e access to st	tudent reco	ds and to sign fo ☐ Yes	orms relat	ted to my child.	
n case of accident or serious illness esignated above, the school will co	s, the school will ontact the physici	contact the pa	arent. If the or will make	school is unable necessary arrar	to contac ngements	ct the parent or per for immediate trea	son itment.
ayment of the fees will be assume	d by parent/guar	dian.					
nave reviewed and understand the	e conditions of the	e Student Clin	ic Card.				
I authorize I do not autho	rize						
ne School District of Pinellas, Flor hich would allow Pinellas School eferenced on my child's individua ESE) services it provides to my chi is/her IEP whether or not I give	ols to verify Me il educational pla nild while at scho	dicaid eligibili an (IEP) and	ity, bill Med receive Me	dicaid for reimb dicaid reimburs	ursable ( ement fo	Certified School N r Exceptional Stud	fatch serv lent Educa
Signalure of Parent/Guardian					De	ate	-

NAME				<u> </u>	GRADE			
Last		N. S.	First			Middle		
Date	Reason		Time in	Time out	Outcome .	Sig	nature	
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