

## Student Emergency Information Form

### Student Information

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Please indicate any health conditions that require treatments, procedure, medications, or health monitoring for your child during the school day:**

 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

### Parent/Guardian Information

**Mother/Guardian:** \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Pager: \_\_\_\_\_

**Father/Guardian:** \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Pager: \_\_\_\_\_

e-mail address: \_\_\_\_\_

### Emergency Contacts

**Please list two contacts who will be called ONLY in case of an emergency and you cannot be reached.**

**Name:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

**Name:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

The principal and/or school nurse may share health information with individuals who have responsibilities for my child. I authorize District officials to contact the persons named on this form and authorize the named physician to render to my child whatever emergency treatment deemed necessary. If the physician, other persons named above, or parent cannot be reached, the District officials may take whatever action they deem necessary for the health of my child. I will not hold Greenville County Schools financially responsible for the emergency care and/or transportation of my child. I will keep the school informed of any changes on this form.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Please read and complete the information requested below:**

### Medicaid Release Statement

*By signing this form, I give Greenville County Schools permission to provide health-related services to my child. I understand that if my child is Medicaid eligible, the District may bill the South Carolina Medicaid Program for the services and that Medicaid will pay the District for providing these services. By signing this form, I give Greenville County Schools permission to release any information related to these services that may be necessary for processing Medicaid claims. I understand that Medicaid payment for services provided by Greenville County Schools will not affect any other Medicaid services for which my child might be eligible.*

Child's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Child's Medicaid Number: \_\_\_\_\_ Parent/Guardian's Signature: \_\_\_\_\_