250-180 Rev. 2010
PLEASE PRINT WITH BLACK INK

TEACHER: ______________________________

GREENVILLE COUNTY SCHOOLS

Student Emergency Information Form

Student Information

Last Name: ________________________________ First Name: ________________________ Middle Initial: _____

Name Called: ____________________ Grade: ______ Birth Date: ___________Home Phone: __________________

Home Address: ____

PLEASE INDICATE ANY HEALTH CONDITIONS THAT REQUIRE TREATMENTS, PROCEDURES, MEDICATIONS, OR HEALTH MONITORING FOR YOUR CHILD DURING THE SCHOOL DAY. PLEASE LIST THE PHYSICIAN TREATING YOUR CHILD AS WELL:

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Parent/Guardian Information

Mother/Guardian: ____________________________ Work Phone: ________________ Cell Phone: _____________

Father/Guardian: ____________________________ Work Phone: ________________ Cell Phone: _____________

Emergency Contacts

*Please list two contacts that 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 person 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 The School District of Greenville County 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 theses 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: ____ Child's Medicaid Number: ________________________

Parent/Guardian's Signature: ____