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:

_____

_____

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: _____