250-180 Rev. 2013
PLEASE PRINT WITH BLACK INK

GREENVILLE COUNTY SCHOOLS

Teacher: _____

Student Emergency Information Form

Student's Name: _____ Grade: _____ Birth Date: _____

Home Address: _____

Please indicate any health conditions that require treatments, procedures, medications, or health monitoring for your student during the school day. Please list the physician treating your child as well:

_____

_____

_____

Mother/Guardian: _____ Work Phone: _____ Cell: _____ Home: _____

Father/Guardian: _____ Work Phone: _____ Cell: _____ Home: _____

*Emergency Contacts: Please list two contacts that will be called **ONLY** if you cannot be reached in an emergency.*

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ 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 Greenville County Schools 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: _____

Consent for Treatment, Release of Information, and Medicaid Reimbursement

Greenville County Schools (the District) requests your permission to bill and receive payment from Medicaid for services as permitted under Part B of the individuals with Disabilities Education Act (IDEA), and as set forth in your child's Individualized Education Program (IEP). The District may also bill Medicaid for psychological evaluation services, **nursing services**, and other health-related services billable to Medicaid without the requirements of an IEP.

This consent also allows the District to release and exchange medical, psychological, and other personal identifiable confidential information, as necessary, to the Department of Health and Human Services regarding services provided to your child.

Prior to this request for consent, you received *Notification of Use of Public Benefits (Medicaid)*. A signed consent for release of information to bill Medicaid is a one-time consent and is not required annually. The District will, however, provide you annual written notification of your rights before Medicaid accesses your child's benefits to pay for services under the IDEA. The District will operate under the guidelines of Part B of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding your child's treatment and provision of services.

Medicaid reimbursement for services provided by the District will not affect any other Medicaid services for which your child is eligible. Granting consent is voluntary on your part and may be revoked at any time. Granting or denying consent for Medicaid billing does not impact any district-provided services for your child.

Your signature below authorizes the District to seek reimbursement from Medicaid for services included in your child's Individualized Education Program (IEP). ***In addition, non-IEP services including psychological evaluations, nursing services, and other health-related services may be billed for reimbursement.***

Student's Name: _____ Date: _____ Students Date of Birth: _____

Student's Medicaid Number: _____ Signature of Parent/Guardian: _____