SY 2022-2023

OKALOOSA COUNTY SCHOOL DISTRICT Student Intervention Services Student Medical Information & Parent Consent Please print all information clearly in ink

MIS 6344	
REV. 6/2022	

Student						
School	ast) G l	rade	(First)		(M.I.)	(DOB-M/D/Y)
How does your child get to s	chool? Car	Walk	Bus #			
Student's Address						
Student Lives with				-		
Mother/Guardian's Name				-		
Home Phone	Cell Pho	one		Work Ph	none	
Father/Guardian's Name						
Home Phone	Cell Pho	one		Work Ph	one	
Primary Care Physician			Specialist _			
•	(Name and office num	nber)	 •	(Na	me and office n	umber)
authorized to act on behalf of y transported to the nearest emer transport. Name/Relationship:	rgency facility. The stude	ent's parent / guar	dian will be financ	_Phone Nur _Phone Nur _Phone Nur _Phone Nur	nber:nber:	
Does your child have any me explain:	edical conditions the s	chool should be	aware of?	No	Yes, if yes, give	diagnosis and
Medication Currently Prescr	ibed:	Reason/use fo	or medication:			
School Board Policy requires tha 1) Must be accompanied by a Di parent / guardian in its original due to the possibility of an allerg	spersion of Medication f container properly labe	orm (MIS 5163) si led; 3) First dosag	gned by a parent o e of any <u>new</u> medi	or legal guard ication <u>shall n</u>	ian; 2) Medicatio n <u>ot</u> be administere	n must be brought by ed during school hours

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OKALOOSA COUNTY SCHOOL DISTRICT Student Intervention Services Student Medical Information & Parent Consent

MIS 6344	
REV. 6/2022	

Student		
(Last)	(First)	(M.I.)
PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES		
The School Health Services Program is designed to preventative and emergency school-based health so School District. As required in Section 381.0056, Flor children while seeing to enhance their learning providing school health services for all our public practical nurse who is supervised by a registered of those staff members who have a legitimate need to	ervices, in accordance with The School Healt orida Statutes, our School Health Services Pla g. The Okaloosa County School District ha s schools. Your child's school will be staffe nurse. All student health information is ke	ch Services Plan for the Okaloosa County an helps to promote health and wellness is contracted with a vendor to assist in ed with a health technician or licensed ept confidential and is only shared with
* Please indicate if you want your child to participate	pate in these school health room services l	oy checking yes or no.
Nursing / health assessmentsYES	n and health care proceduresYES	
In the event of an accident or serious illness, you we contact the emergency contacts on the previous preatment for your child, and exchange medical in care for your child.	page and will take whatever actions are ne	ecessary to provide emergent care and

* Please indicate if you want your child to participate in these screenings by checking yes or no.

in the school clinic and are available to parents/guardians upon request.

	ngYESNO nt & Weight (BMI)YESNO			
My signature indicates my parental consent, understanding, and agreement.				
PRINT – PARENT / GUARDIAN	SIGNATURE – PARENT / GUARDIAN	DATE		

Florida Statute 381.0056(7)(d), mandates regular health screenings for public school students. The screenings include Vision- PreK, 1st & 3rd, Hearing – PreK, Kg, 1st & 6th, Height and Weight (BMI) – PreK, 1st, 3rd, & 6th and Scoliosis - 6th grade only. Parents are encouraged to seek medical evaluation of problems identified through the screening process. Results of screenings will be available

MEDICAID BILLING CONSENT

FOR STUDENTS COVERED UNDER STATE MEDICAID PROGRAMS ONLY

I understand and give my consent to the school district to share information about my child with the State Medicaid Agency (State of Florida Agency for Health Care Administration), its fiscal agent, and the school district's Medicaid billing agent or billing facilitator for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child. I understand that I may withdraw this consent to release information for Medicaid reimbursement at any time. I understand that if I refuse to give my consent or withdraw this consent, the school district will continue to provide all required services necessary for my student to receive an appropriate education at no charge to my child in accordance with 34CFR§300.154(d)(2)(v)(D) or other services provided outside of any IEP. If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.

PRINT – PARENT / GUARDIAN	SIGNATURE – PARENT / GUARDIAN	DATE		
My signature indicates my parental consent, understanding, and agreement.				
34CFR§300.154(d)(2)(v)(D) or other services provided outside of any IEP. If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.				