2024-2025

Marion Charter School

Contact, Medical & Emergency Form
39 Cedar Road, Ocala, FL 34472
(352) 687-2100 – phone *(352)687-2700 fax

Office use:
Date - ______________
Student # ______________
Teacher - ______________

This form is to be completed annually by parent/guardian ONLY. Please notify the school of any changes in this information throughout the school year.

STUDENT INFORMATION: please print legibly

Last Name:	First Name:	Middle Name:	Jr., II, etc.:
Birth Date: ____/____/____	Age:	Grade:	Gender:

Residence Address:	Apt:	City:	State:	Zip:
Mailing Address:	Apt:	City:	State:	Zip

PARENT / GUARDIAN INFORMATION:

Mother's/Guardian's Legal Name:	Place of Employment:	Work phone:
Address(if different from home) Email Address:	Home phone:	Cell phone:
Father's/Guardian's Legal Name:	Place of Employment:	Work phone:
Address (if different from home) Email Address:	Home phone:	Cell phone:

ADDITIONAL STUDENT INFORMATION:

STUDENT LIVES WITH: (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other: __________________
(ATTACH any restraining order or similar judicial pleading that prohibits parental access. If a court-adopted parenting plan is in effect, attach a copy)

OTHER BROTHERS/SISTERS ENROLLED IN MARION COUNTY PUBLIC SCHOOLS

Name: ______________________________ Grade: _________	Name: ________________________________ Grade: _____________	Name: ________________________________ Grade: ____________

SPECIAL HEALTH PROBLEMS AND/OR NEEDS REQUIRING MEDICAL ASSISTANCE AT SCHOOL

- ☐ **NONE – Student has no known health condition(s) or medical needs(s)**
- ☐ **ADHD/ADD**
- ☐ **Life Threatening Allergies (specify)** ______________
- ☐ **Non-Life Threatening Allergies (specify)** ______________
- ☐ **Asthma – History of Asthma ONLY** ☐
- ☐ **OTHER:** ______________
- ☐ **Austim (ASD)**
- ☐ **Bleeding Disorder**
- ☐ **Cerebral Palsy**
- ☐ **Cancer (specify)** ______________
- ☐ **Cardiac Condition (specify)** ______________
- ☐ **Crohn's Disease**
- ☐ **Cystic Fibrosis**
- ☐ **Type 1 Diabetes**
- ☐ **Type 2 Diabetes**
- ☐ **Feeding Tube (specify)** ____________
- ☐ **Hypoglycemia**
- ☐ **Lupus (SLE)**
- ☐ **Kidney Disorder (specify)** ________________
- ☐ **Seizure Disorder/ Epilepsy**
- ☐ **Sickle Cell Disease**
- ☐ **Spina Bifida**
- ☐ **Tracheostomy**
- ☐ **Mental/Behavioral Health Disorder (specify)** ______________________

Medical Services needed at SCHOOL: (parent / Guardian authorization & Physician order required)
____

School use only: Received by ________________ Date _______________ Reviewed by nurse __________________ Date _____________ ☐ Comments on back

ALL PARENT/GUARDIAN CONTACT INFORMATION MUST BE VERIFIED AND UPDATED BY THE PARENT/GUARDIAN USING SKYWARD FAMILY ACCESS, IF YOU DO NOT HAVE AN ACCOUNT PLEASE CONTACT THE SCHOOL OFFICE.

CHILD PICK-UP/EMERGENCIES: I agree that the school may release my child to the following people and provide pertinent information related to this release. Any previous contacts not listed below will be removed. *Enter contact name(s) as they would appear on the driver's license.* Contacts must be updated yearly.

Full Name: ____ **Relationship:** ______________________________ **Phone:** ___________________________
Full Name: ____ **Relationship:** ______________________________ **Phone:** ___________________________

I understand and agree to the following;

- **My Child's records and information may be shared with the School Boards health care partners as needed to provide and evaluate health care services.**
- **If my child is or becomes Medicaid eligible, reimbursable services may be billed to Medicaid and my child's information and records may be provided to Medicaid and/or the School Board's Medicaid processing agents or the School Board's health care partners. Consent for Medical billing may be revoked at any time and if consent is revoked, these services will be provided at no cost.**
- **In case of emergency, my child may be transported by Emergency Medical Services to a hospital and provided treatment, and I am responsible for charges related to the transportation and medical treatment.**
- **My child will participate in the School Health Services Program. If I wish for my child to opt out of any School Health Services, I will provide a written letter to the school principal. For more information about our School Health Services program visit www.marionschool.net/HealthServices.**

Student Physician (print) : ____ **Physician Phone Number:**_________________________
Parent/Guardian Name (Print): ________________________________ **Parent/Guardian Signature:** ____________________________________

Equal Opportunity School