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:

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

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

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 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:**_____

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**Consent for Treatment, Release of Information, and Reimbursement for Non-IEP Nursing Services**
**By my signature below, I consent for Greenville County Schools to:**

- provide Non-IEP Nursing services to my child;
- release and exchange the following information from my child's record to the Department of Health and Human Services (Medicaid Agency) for the purpose of billing for the Non-IEP Nursing services provided to my child – information about the service provided, my child's name, date of birth, Medicaid or health insurance number, gender, and my contact information;
- bill the Medicaid Agency for the Non-IEP Nursing services; and
- receive payment from the Medicaid Agency for the Non-IEP Nursing services that the District provides to my child.

**I understand that:**

- Medicaid reimbursement for Non-IEP Nursing services provided by the District will not affect any other Medicaid services for which my child is eligible.
- The District will continue to provide required Non-IEP Nursing services for my child at no cost to me even if I refuse to allow billing for services.
- Granting consent is voluntary on my part and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the con sent was revoked).
- The District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of Non-IEP Nursing services.

**Student's name:** _____ **Date:** _____

**Student's date of birth:** _____ **Student's Medicaid #:** _____

**Signature of Parent/Guardian:** _____

SCDE 7.29.16