LEGACY CHARTER SCHOOL

*Where students **create** a lasting **legacy***

STUDENT HEALTH AND EMERGENCY RECORD

Full Name:_____ **Allergy:** (food, medicine, latex etc.)_____

Grade: _____ Age: ____ DOB:___/_____/____ Sex:_____ Ethnicity:_____ SSN: _____-_____-_____

Name of Parent/Legal Guardian: _____ Phone _____

ALL CURRENT MEDICATIONS

Drug	Dose	Time	Route	Physician/Phone

IN CASE OF EMERGENCY

INSURANCE/CHILDS MEDICAID & NUMBER	HOSPITAL OF CHOICE	PRIMARY PHYSICIAN/PHONE	DENTIST/PHONE

ATTENTION: the following information requires complete honesty in order that our Student Health Office can better care for your child's health care needs.

CURRENT MEDICAL HISTORY (CHECK ALL THAT APPLY) AND ADD ANY CONDITION NOT LISTED BELOW:

ADHD/ ADD		Frequent headaches		Sickle Cell Anemia	
Arthritis		Frequent tonsillitis		Vision Impairment	
Asthma		Hearing Impairment			
Bladder Disorder		High Blood Pressure			
Diabetes Type I or II		Seizures			

Parent/Legal Guardian Signature _____ **Date** _____

EMERGENCY CONTACT NUMBERS

STUDENTS WILL BE RELEASED TO PERSONS LISTED BELOW UNLESS GIVEN A NOTE FROM THE PARENT/LEGAL GARDIAN

Name	Relationship to Student	Phone Number

For our reference, if divorced or separated, does Legacy Charter School have the legal custody papers in the child's permanent records? YES _____ NO _____

The principal and/or school nurse may share health information with individuals who have responsibilities for my child. I authorize Legacy Charter School 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, Legacy Charter School officials may take whatever action they deem necessary for the health of my child. I will not hold Legacy Charter School, officials and staff responsible for the emergency care and/or transportation of my child. I will keep Legacy Charter 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 Legacy Charter School permission to provide health-related services to my child. I understand that if my child is Medicaid eligible, Legacy Charter School may bill the South Carolina Medicaid Program for the services and that Medicaid will pay Legacy Charter School for providing these services. By signing this form, I give Legacy Charter School permission to release any information related to these services that may be necessary for processing Medicaid claims. I understand that Medicaid payment for services provided by Legacy Charter School 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: _____