School Board of Brevard County, Florida
HEALTH CARD

NAME _____ DOB _____ GRADE _____ SEX _____
LAST FIRST MI

ADDRESS _____ HOME PHONE _____
STREET CITY ZIP

PARENT _____ EMPLOYER _____ WORK PHONE _____ CELL PHONE _____

PARENT _____ EMPLOYER _____ WORK PHONE _____ CELL PHONE _____

HEALTH CONDITIONS/SPECIAL NEEDS – PLEASE CHECK

☐ ADD/ADHA ☐ CYSTIC FIBROSIS ☐ SICKLE CELL DISEASE ☐ OTHER _____
☐ ASTHMA ☐ DIABETES ☐ DEVELOPMENTAL DELAY ☐ OTHER _____
☐ BLEEDING DISORDER ☐ EPILEPSY /SEIZURES ☐ SURGERY ☐ OTHER _____
☐ CANCER ☐ KIDNEY DISORDERS ☐ PSYCHIATRIC CONDITIONS
☐ CARDIAC CONDITIONS

Will any medications or treatments be required at school? ☐ YES ☐ NO

DAILY MEDICATIONS: HOME 1. _____ **SCHOOL 1.** _____

2. _____ **2.** _____

DIABETES: ☐ TYPE I ☐ TYPE II

EMERGENCY MEDICATION: _____

EMERGENCY MEDICATION: EPINEPHRINE (EPIPEN) ☐ HOME ☐ SCHOOL ☐ BOTH

ALLERGIES: ☐ INSECT BITES SPECIFIC ALLERGIES:

☐ FOODS _____

☐ MEDICINE _____

☐ OTHER _____

SPECIAL EQUIPMENT:

☐ Glasses/contacts ☐ Arm/Leg Braces ☐ Shunt ☐ Internal Defibrillator

☐ Hearing Air ☐ Gastric Tube ☐ Catheter ☐ Other Equipment

☐ Wheelchair ☐ Tracheostomy ☐ Vagal Stimulator _____

As required by F.S. 1014.06(1), parents must authorize healthcare services to be provided for their child/ward by a healthcare practitioner, as defined in F.S. 456.001, or someone under the direct supervision of a healthcare practitioner, should the need arise for such treatment, while my child/ward is under the supervision of the school.

The Health Cards have been amended to authorize such treatments including, but not limited to major or minor injury or illness reported or observed while the child is at school. This does not authorize the dispensing of medication or school screenings such as vision, hearing, or scoliosis, or height and weight. These services require a separate consent which was included in the original registration paperwork.

Do you authorize healthcare services? ☐Yes ☐No

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (Only one parent/guardian signature is required)

Student's Physician's Name _____ Phone: _____

Parent/Legal Guardian Name (Please Print): _____

Parent/Legal Guardian Signature: _____