School Board of Brevard County, Florida HEALTH CARD

NAME _____ DOB _____ GRADE _____ SEX _____
LAST FIRST MI

ADDRESS _____ HOME PHONE _____
STREET CITY ZIP

PARENT/GUARDIAN _____ EMPLOYER _____ WORK PHONE _____ CELL PHONE _____

PARENT/GUARDIAN _____ 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

Parents/Guardian must bring doctor's orders, medication in original container, and complete appropriate paperwork prior to distribution of medication at school.

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**	_____

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: _____

Revised: 02/28/2023 CR