STUDENT EMERGENCY CONTACT CARD

Emergency Contacts

Office Use Only

School #

FSI#

Date Enrolled

- ❒ MEDICAL
- ❒ RESTRAINING ORDER
- ❒ SPECIAL NEEDS
- ❒ OTHER

In case of an emergency, it is imperative that the school be able to reach the student's Parent (as defined below). Please fill in the information on both sides of this card carefully and accurately. Please use ink and print clearly. *"Parent" includes any adult exercising supervisory authority over a student (section 1000.21(5) Fla.Stat.)* **Grade ___**

STUDENT _____ ❒ Male _____
Last Name First Middle ❒ Female Teacher/Advisor

_____ _____ _____ _____ _____ ___ _____
Home Address City State/Zip Home Phone Birthdate Birthplace

_____ Lives with: ❒ Mother ❒ Father ❒ Both Parents ❒ Other _____
Mailing Address, if different from above City State/Zip Address change? ❒ No ❒ Yes If Yes, please contact the School Office.

REGISTERING PARENT _____|_____
Last Name First Email Employer

_____|_____|_____|_____|_____
Home Address City State/Zip Home Phone Work Phone Cell Phone Pager

OTHER PARENT _____|_____
Last Name First Email Employer

_____ _____|_____|_____|_____
Home Address, City State/Zip Home Phone Work Phone Cell Phone Pager

Other children at home: (1) _____|___|_____ (2)_____|___|_____
Name Grade School Name Grade School

Languages spoken at home: 1. _____ 2. _____

Has a court prohibited the parent from having contact with the student? ❒ No ❒ Yes If Yes, contact the School Office.

AUTHORIZED Release/Contact

Please list the names of persons to whom we may release your child or who we may contact if we cannot reach you. **NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PERSONS LISTED BELOW.** In selecting someone to whom you authorize the release of your child, consider: Is this person prepared to handle any special medical needs required by your child?

I/we hereby authorize contact with, release of emergency related information, or release of the student to the following persons in the event of illness, injury, evacuation or other emergency that may occur while students are in school.

Name	Relationship	Home Phone	Work or Cell Phone
Out-of-state contact:			

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes

Parent's Signature _____/_____ **Date** _____ **Relationship** _____

Continued ⇨

STUDENT:

SCHOOL:

STUDENT EMERGENCY CONTACT CARD
Medical Information

STUDENT _____
Last First Middle

MEDICAL/HEALTH INFORMATION

Medication: Does your child take medication? ☐ **No** ☐ **Yes**

Medication	Dosage	Hour(s) given

If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. Also a **"Medication/treatment Authorization"** form, must be completed and signed by the physician and the parent and must be on file.

Health Insurance Information: *Please check appropriate box.*
❑ Family Health Insurance ❑ Florida Healthy Kids ❑ Florida KidCare ❑ Other:_____
❑ Medicaid# _____ ❑ No Health Insurance

Physician/Health Care Provider_____ Phone No. _____

Health Plan/Group Name _____ Policy No. _____

Dentist _____ Phone No. _____

Vision and/or Hearing Information:
❑ Wears glasses/contacts: YES/NO ❑ Wears hearing aid(s) YES/NO

Medical Conditions: Please check the appropriate boxes if your child has any of the following:
❑ Severe Allergies ❑ Food/Environmental ❑ Stinging Insects/Bees ❑ Medicines/Drugs
❑ Other
Please explain: _____

Requiring: → ❑ Benadryl ❑ EpiPen Other _____

❑ Asthma If checked, ❑ uses inhaler ❑ on daily medication
❑ Seizures If checked, on medication? ❑ Yes ❑ No
❑ Diabetes If checked, insulin dependent? ❑ Yes ❑ No
❑ Movement limitations: _____
❑ Other (please explain): _____
❑ Recent illness, hospitalization or surgery. If checked, please provide date(s) and description(s):

_____

_____

We recommend that you duplicate this card for your records.

EMERGENCY TREATMENT AUTHORIZATION

I the undersigned parent(s) of _____ _____, do hereby give authorization and consent to the school to obtain emergency medical care and necessary emergency transportation to a healthcare facility

_____ _____
Parent Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with school officials and emergency personnel who have a legitimate medical/educational purpose for accessing such medical records and information.

_____ _____
Parent Signature Date

EMERGENCY DISMISSAL

In the event of a severe storm or other unscheduled emergency dismissal your child is instructed to:

❑ Walk Home
❑ Ride Public Transportation
❑ Ride School Bus as usual
❑ Ride Home with parent only
❑ Ride Home with friend identified on authorized contact list

_____ _____
Parent Signature Date