

STUDENT EMERGENCY CONTACT CARD

Emergency Contacts



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 ____

Office Use Only

School # _____

FSI# _____

Date Enrolled _____

- MEDICAL
- RESTRAINING ORDER
- SPECIAL NEEDS
- OTHER

STUDENT

Male _____
 Female _____ Teacher/Advisor _____
 Last Name _____ First _____ Middle _____
 Home Address _____ City _____ State/Zip _____ Home Phone _____ Birthdate _____ Birthplace _____
 Mailing Address, if different from above _____ City _____ State/Zip _____ Lives with: Mother Father Both Parents Other _____
 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):

EMERGENCY TREATMENT AUTHORIZATION

I the undersigned parent(s), _____, 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