Teacher: _____
(Homeroom Teacher)
Grade: _____

STUDENT EMERGENCY AND HEALTH INFORMATION

THIS INFORMATION IS CONFIDENTIAL, BUT MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL.

Date:_____
❑ **Medical Conditions- SEE BELOW**

Student's Full Legal Name:_____ DOB: _____ I.D. #_____
Last First Middle

Address: _____Home Phone: (_____)_____
Street City Zip Code

STUDENT LIVES WITH: *(Circle one)* **Both Parents** **Mom** **Dad** **Guardian** E-Mail Contact: _____

Father: Natural / Step / Foster (please circle one)
Name:_____
Cell Number: _____
Place of Employment:_____
Occupation:_____
Phone at Work:_____

Mother: Natural / Step / Foster (please circle one)
Name:_____
Cell Number: _____
Place of Employment:_____
Occupation:_____
Phone at Work:_____

Guardian: (Please provide a copy of Court Papers to school)
Name:_____
Cell Number: _____
Place of Employment:_____
Occupation:_____
Phone at Work:_____

MUST BE FILLED OUT - Person(s) who will care for student in case neither parent can be reached **(only the people listed may pick up your child with proper identification)**:
Name: _____ Relationship: _____ Phone: (Home)_____ (Work) _____ (Cell) _____

Name: _____ Relationship: _____ Phone: (Home)_____ (Work) _____ (Cell) _____

List all children in family in order of birth:

Name (first and last)	Age/Sex	Living at Home	Grade/Teacher	School

Please check all medical conditions that apply to your child: *(Check Box & Circle if Required)*
❑ADD/ADHD ❑Asthma ❑Migraine ❑Hearing Loss ❑Glasses/Contacts
❑Allergies: Food/Latex/Insects/Environmental Specify _____❑Medication ❑Epi-pen
❑Diabetes/Type_____ Blood Testing at School? Y or N Insulin? Y or N
❑Heart Disease/Kidney Disease_____ Surgery? Y or N Medication? Y or N
❑Seizure/Type_____ Medication? Y or N
Any other condition requiring observation or Medication:_____
DOCTOR'S NAME: _____PHONE: _____

Parent's Statement: I accept responsibility for notifying the school of any changes of address or phone number, home or business and any change in health status of my child. Students may receive State specified health services and vision, hearing, weight, BMI and scoliosis screening. If the vision screening shows a need for a follow-up vision examination, and if your child is eligible, Florida Heiken Children's Vision Program, Florida's Vision Quest or other licensed optometrist may provide a FREE vision examination by a licensed optometrist, which may include dilation, refraction, and glasses, if prescribed. I agree to a mutual exchange of information between the Florida Heiken Children's Vision Program, Florida's Vision Quest, referring providers, Department of Health and my County Public School of any and all necessary information to enable my child to receive services; and I agree to release and hold harmless the County School Board, Miami Lighthouse for the Blind & Visually Impaired, Florida Heiken Children's Vision Program, and Florida's Vision Quest providers from any and all responsibility and liability for any injury or claim resulting from my child's participation in the Florida Heiken Children's Vision Program or Florida's Vision Quest. Students may be exempt from any of these services, if the parent or guardian requests such exemption in writing. In the event of serious illness or accident and I cannot be immediately contacted, I give permission to have my child transported by ambulance or other conveyance to a doctor's office or hospital for immediate attention, and I assume responsibility for payments of same. In case of an accident or illness where immediate treatment is not needed, but where my child is unable to remain in school, I request the school to contact me. If I am unable to be reached, I request that one of the persons listed above be contacted to care for my child until I can be reached. These people have permission to transport my child. I understand that certain educational records of my child will be shared with District health care partners, as needed, to provide and evaluate health services; and that certain medical treatment records of my child, created by health care personnel at school, may be shared with school officials who have a legitimate need for access.

_____ ***I understand that the information on this form will be the official student directory information.***
Signature of Parent or Guardian **Date**

FILL OUT COMPLETELY—SIGN—RETURN TO SCHOOL