

Student Emergency Contact Card

This form shall be updated every year

<i>For Office Use Only:</i>	<input type="checkbox"/> <i>Medical</i>
<i>School #:</i>	<input type="checkbox"/> <i>Court Order</i>
<i>Student #:</i>	<input type="checkbox"/> <i>Special Needs</i>
<i>Date Enrolled:</i>	<input type="checkbox"/> <i>Other</i>

In the 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. The names of both parents of a student (as defined in the Section 1000.21(5), Florida Statutes), the registering parent and the non-registering parent, of a student shall be listed on the emergency contact card as persons authorized to pick up the child from school except where a court order has revoked the parental rights and a certified copy of such court order has been provided to the school office. Both parents shall designate on the Emergency Contact Card those persons authorized to pick up their child from school. No parent shall delete or in any way alter the names provided by the other parent on the Emergency Contact Card.

Grade:	Student Information	Last Name:	First:	Middle:	
		Teacher (elementary school only):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade Level:	
		Home Address:	City, State, Zip:	Home Phone:	
		Mailing Address (If different from above):	City, State, Zip:	Student Cell Phone:	
		Date of Birth: / /	Student lives with:	Student Email:	
		Check any that apply to student residence: <input type="checkbox"/> Medical <input type="checkbox"/> Court Order <input type="checkbox"/> Special needs <input type="checkbox"/> Other	Has student changed address since last registration? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a court order on file that prevents a parent from having contact with the student? <input type="checkbox"/> No <input type="checkbox"/> Yes, contact school	
Student Identification Number:	Registering Parent	Last Name:	First:	Cell Phone:	
		Home Address (if different from student):	City, State, Zip:	Home Phone:	
		Employer:	Work Phone:	Parent email:	
	Other Parent	Last Name:	First:	Cell Phone:	
		Home Address (if different from student):	City, State, Zip:	Home Phone:	
		Employer:	Work Phone:	Parent email:	
	Authorized Release/Contact	Please list the names of persons to whom we may release your child or whom 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 whether this person is 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, evacuation, or other emergency that may occur while the student is in school.			
		Name:	Relationship:	Phone:	
Non-Registering Parent Authorized Release/Contact	I declare that the information on this card is true and correct. I will notify the school office immediately of any changes.				
	Signature:	Date:	Relationship:		
	This section may be completed only by the non-registering parent in order to designate additional persons who may pick up the student. The registering parent may not alter this section of this card. The non-registering parent may not alter any other portion of this card.				
	Name:	Relationship:	Phone:		
I declare that the information on this card is true and correct. I will notify the school office immediately of any changes.					
Signature:	Date:	Relationship:			

The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by school staff on a need-to-know basis.

Broward County Public Schools Student Emergency Contact Card

Student Last Name:

First:

Middle:

Health Services Consent	Indicate which services you give consent to and would like your child to receive at school with an "x" in the appropriate check box.	
	Care and treatment for illness and injury <input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis screening <input type="checkbox"/> Yes <input type="checkbox"/> No
	Vision screening <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing screening <input type="checkbox"/> Yes <input type="checkbox"/> No
	Growth and development screening (body mass index) <input type="checkbox"/> Yes <input type="checkbox"/> No	
I consent to my child receiving all school health services indicated above. I understand if consent is granted, SBBC will disclose my child's education records (including medical information) to nursing vendors who provide treatment to my child.		
Parent or Guardian Signature: _____ Date: _____ Relationship: _____		
Health Insurance and Providers	Please check appropriate box: <input type="checkbox"/> Family Health Insurance <input type="checkbox"/> Florida Kid Care <input type="checkbox"/> Florida Healthy Kids <input type="checkbox"/> None	
	If NONE, do we have your permission to forward the parent's name and phone number to Florida Kid Care Insurance for health insurance screening to see if you may be eligible for health insurance coverage? If Yes, please sign here:	
	Health Care Provider: _____	Phone: _____
Medical Information	Is your child currently diagnosed and followed by a healthcare provider for any of the following?	
	<input type="checkbox"/> Asthma (currently uses daily or emergency medication)	
	<input type="checkbox"/> Seizure/Epilepsy (not including febrile seizures)	
	<input type="checkbox"/> Diabetes	
	<input type="checkbox"/> Anaphylaxis (Life threatening allergic reaction requiring emergency medication)	
	<input type="checkbox"/> Recent illness/hospitalization/surgery (describe)	
<input type="checkbox"/> Other _____		
Does your child require medication while at school? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your child wear glasses/contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your child wear hearing aid(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Release of Medical Information and Emergency Treatment	I hereby authorize for my child's medical information, parental contact information, and other health information (collected from health services provided at school, including information stored electronically) to be shared with emergency personnel and health department officials to address conditions of public health importance, including information to meet and to prepare for potential or confirmed health conditions. For students receiving health services from school or District staff and/or contracted partners, I also authorize the District to share my child's identifiable health information and related demographics with the Florida Department of Health to conduct monitorings to assure program compliance by the District and schools, and assess the delivery of services.	
	Parent Signature: _____	Date: _____
Medical and other information will be disclosed without consent from the parent/eligible student in case of health emergencies, as permissible by the Family Educational Rights and Privacy Act (FERPA). The school will call for emergency medical care as deemed necessary. Emergency transportation to a health care facility, as determined by paramedics, will be authorized.		
Dismissal Information	Regular Dismissals Procedures. On a typical day, how will your child leave school?	
	<input type="checkbox"/> Ride in Car	<input type="checkbox"/> Ride School Bus
	<input type="checkbox"/> Attend ON-site after-care program	<input type="checkbox"/> Attend OFF-site after-care program
Emergency Dismissals Procedures. In the event of a severe storm or other unscheduled emergency your child is instructed to:		
<input type="checkbox"/> Walk home	<input type="checkbox"/> Ride School Bus as usual	
<input type="checkbox"/> Ride home with parent only	<input type="checkbox"/> Ride home with person indicated on authorized contact list	
Siblings and Home Language	Last Name: _____	First Name: _____
	_____	_____
	_____	_____
	_____	_____
Please list any other languages spoken at home: _____		
Survey Questions	Please assist us in understanding the needs of our school community by answering the following questions. Please check all that apply:	
	Does your child have access to a computer in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have home internet access?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child have access to the internet on your home computer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have internet access outside your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate the method of contact you prefer: <input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email		