Duval County Public Schools
Emergency Contact Information, Authorization for Release of Student from School and Consent to Receive School Health Services

INSTRUCTIONS: Parent/Guardian/Surrogate please complete and return to school. Signature and date are required.

Student Legal Name (last, first, middle)				
Date of Birth	**Student #**	**School**	**Grade**	**Homeroom**

Student Address: House number and street name, apartment #, city, state, zip code, housing development name (if applicable)

Emergency Contact Information and Authorization for Release of Student from School:

1. **PRINT all information.**
2. **INCLUDE EACH PARENT/GUARDIAN/SURROGATE ON THIS LIST. Circle the appropriate relationship to student.**
3. **List all contacts who may act on your behalf in case of sudden illness, accident, or emergency.**
4. **List names in the order they should be contacted.**
5. **The school will also use this information to determine who may pick up your student from school (non-emergency).**

Last Name	First Name	Relationship to Student	Daytime Contact Phone Number	Emergency Contact?	Pick up from school (non-emergency)?
		Parent/Guardian/Surrogate		☐ YES ☐ NO	☐ YES ☐ NO
		Parent/Guardian/Surrogate		☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

Does the student have allergies? Yes ☐ No ☐
If yes, please list below:

List any health conditions including but not limited to diabetes, asthma, seizure disorder/epilepsy, cardiac disorder:

Doctor/ Primary Health Care Provider: Name: _____ Phone: _____ Fax: _____

CONSENT TO RECEIVE SCHOOL HEALTH SERVICES

The Florida Department of Education and the Florida Department of Health work in cooperation to coordinate the School Health Services Program as mandated in Florida Statute sections 381.0056, 381.0057, and 402.3026. The School Health Services Program provides the following services:

- Care and treatment for illness, injury and/or emergency care
- Referral and follow-up
- Health promotion and basic health education
- Nutrition assessment
- Hearing screening
- Scoliosis screening
- Health appraisals and nursing assessment
- Health counseling and consultations
- Preventative dental health and education
- Records review
- Vision screening
- Growth and development screening

I hereby give consent for my child to participate in the School Health Service Program and to receive the services listed above. I understand that I have the right to opt my student out of any of the above services. To opt my student out of any of the above health services, I can log into my parent/guardian Focus account, select C*hild Info*, then select *Forms*, and complete the *Opt Out of School Health Services Form.*

In the event of a serious accident or illness, I request that the school contact me. If I cannot be reached, I request designated school personnel to take or send my child to the hospital determined by Emergency Services personnel. I consent to be responsible for all expenses incurred. In case of an accident or illness where immediate medical treatment is not indicated, but where my child is unable to remain in school, I request the school contact me. If I cannot be reached, I request that one of the persons listed above be contacted to remove my child from school and to be responsible for his/her care. These persons listed have transportation and are immediately available to come to school.

The Florida Department of Health-Duval in conjunction with the Department of Education provides school health nursing services for Duval County Public Schools. I understand that all health-related information I provide to the school regarding my child will be shared between the two agencies as needed in the performance of their duties. I further understand that said information will be shared between agencies in compliance with state and federal laws governing student records and confidentiality requirements.

PRINT *Parent/Guardian/Surrogate Name* _____

Parent/Guardian/Surrogate Signature _____

Date _____