

## Duval County Public Schools

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

**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 <b>TLAM</b> | 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 and | Emergency Contact?  | Pick up from school (non-emergency)?                     |
|-----------|------------|---------------------------|---------------------------|---|--|
|           |            | Parent/Guardian/Surrogate |                           | <input type="checkbox"/> YES <input type="checkbox"/> NO            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|           |            | Parent/Guardian/Surrogate |                           | <input type="checkbox"/> YES <input type="checkbox"/> NO            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|           |            |                           |                           | <input type="checkbox"/> YES <input type="checkbox"/> NO            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|           |            |                           |                           | <input type="checkbox"/> YES <input type="checkbox"/> NO            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|           |            |                           |                           | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

**Health Screenings:** Students will receive non-invasive health screenings pursuant to Florida Statute 381.0056. Non-invasive screenings may include vision, hearing, scoliosis and growth and development (height/weight). These tests may be given individually or in groups. Parents or guardians, however, have the right to request an exemption in writing. If you **DO NOT** want your child to receive any or all of the screenings, write the words "Do Not Screen" in the boxes on the right that apply.

|                         |  |
|-------------------------|--|
| Vision:                 | <input style="width: 95%;" type="text"/> |
| Hearing:                | <input style="width: 95%;" type="text"/> |
| Scoliosis:              | <input style="width: 95%;" type="text"/> |
| Growth and Development: | <input style="width: 95%;" type="text"/> |

|   |   |
|---|---|
| Does the student have allergies? Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, please list below: | List any health conditions including but not limited to heart disease, diabetes, asthma, epilepsy, eye or ear problems:<br><br>Current medications: |
|---|---|

Doctor/ Primary Health Care Provider: Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby give consent for my child to participate in the School Health Service Program and to receive nursing and emergency care at the school, if needed. Screening and evaluation for problems in the areas of vision, hearing, growth and development, nutrition, dental, scoliosis, communicable diseases, blood pressure, speech and language, or other non-invasive health screenings may be done as part of the program.

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 \_\_\_\_\_

EMAIL: \_\_\_\_\_

COURT ISSUES: YES \_\_\_\_\_ NO \_\_\_\_\_

LIVES WITH: MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_