Duval County Public Schools
Emergency Contact Information and Authorization for Release of Student from School

INSTRUCTIONS: Parent/Guardian completes and returns to child's school. Signature and date are required.

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

Student Local Address (house number and street name, apartment number, city, state, zip code) Housing Development (if applicable)

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

1. **PRINT all information.**
2. **INCLUDE PARENTS/GUARDIANS ON THIS LIST.**
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 child from school (non-emergency).**

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

Health Screenings: Students will receive non-invasive health screenings pursuant to Florida Statute § 381.0056(7)(d). Non-invasive screenings may include vision, hearing, scoliosis, height, and weight. These tests may be given individually or in groups. Parents or guardians, however, have the right to request an exemption in writing. *(This exemption will cover all types of screenings.)*

If you **DO NOT** want your child to receive the screenings, write the words **"Do not screen"** here: _____

Do you have health insurance for your child? ☐ Yes ☐ No

Would you like to be contacted about obtaining affordable health insurance? ☐ Yes ☐ No

Does the student have allergies? ☐ Yes ☐ No If yes, please list below:	List any other health conditions such as heart disease, diabetes, epilepsy, eye or ear problems, or other chronic conditions: Current medications:

DOCTOR **/** PRIMARY HEALTH CARE PROVIDER: Name:_____Phone:_____

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: _____