DISTRICT SCHOOL BOARD OF PASCO COUNTY
GRADES 6 – 12 ACCESS AND EMERGENCY INFORMATION CARD

MIS Form #415
Rev. 3/15

☐ Updated Info.

Student _____ **Student #** _____ **DOB** _____ **Grade** _____
Last Name **First** **Middle**

Primary Phone _____

Home Address _____ **City** _____ **Zip** _____

Parent/Guardian	**Parent/Guardian**
Cell Phone	**Cell Phone**
Email Address	**Email Address**
Employed By	**Employed By**
Phone At Work	**Phone At Work**

Person(s) who will care for child in case parent/guardian cannot be reached; these individuals may sign my child out (photo I.D. required):

Name	**Relationship**	**Phone**
Name	**Relationship**	**Phone**
Name	**Relationship**	**Phone**
Name	**Relationship**	**Phone**
Name	**Relationship**	**Phone**

First and last names of brothers/sisters attending Pasco County Schools _____

Person(s) who MAY NOT legally contact or remove my child from school (provide legal documentation) _____

It is the parent/guardian's responsibility to keep the school updated with new information and contact numbers.

PARENTAL CONSENT ON BACK – SIGNATURE REQUIRED

Student _____ **Grade** _____

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Health information must be reported EVERY YEAR.

List any medication(s) your child is currently taking (at home or school) _____

List all health problems and/or allergies (food, medication, sting, etc.) even if previously reported _____

Parent/guardian must notify school cafeteria of food allergies or special nutritional needs of student.

PARENTAL CONSENT

I hereby give my consent for my child to participate in the School Health Services Program. This means that my child will receive vision, hearing, dental, scoliosis, blood pressure, and height and weight screening at certain grade levels. In addition, the school nurse conducts classroom, individual, and small group presentations on health issues such as abstinence, substance abuse prevention, dating and relationship issues, birth control, and sexually transmitted diseases at certain grade levels. If I object to any of these health screenings or programs, I will notify the school in writing.

In case of accident or serious illness, I want to be contacted by the school. If the school is unable to reach me, I hereby authorize the school to contact the physician or dentist indicated below and to follow his/her instructions. If it is impossible to contact this physician or dentist, the school will take whatever actions are necessary to provide care and treatment for my child, and exchange medical information with the provider as necessary to support the continuity of care for my child. I agree to pay all expenses incurred by the handling of this emergency care. In case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain at school, I request that one of the persons listed on the reverse side of this form be contacted and requested to care for my child until I can be reached.

I authorize the District School Board of Pasco County to release and exchange my child's confidential information (e.g., student name, records, and information related to services provided) to agencies of the state of Florida which would allow the District to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's individualized educational plan (IEP), and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. I understand that my child will continue to receive services referenced on his/her IEP whether or not I give consent.

Physician's Name _____ **Phone** _____

Hospital Preference _____ **Phone** _____

Dentist's Name _____ **Phone** _____

My signature indicates my parental consent, understanding, and agreement.

_____	_____	_____
PRINT - PARENT/GUARDIAN NAME	**PARENT/GUARDIAN SIGNATURE**	**DATE**