

**2022-2023 Lafayette County Emergency Information and Medical Update**

Grade: \_\_\_\_\_

In the case of an emergency, it is imperative that the school be able to reach the student's parent (as defined below).  
 Fill in the information on both sides of this form carefully and correctly. Please use ink and print clearly.

<b>Student Information</b>	Last Name: _____		First: _____		Middle: _____		
	Date of Birth: / /		Gender: Male Female		Primary Phone: _____		
	Race: _____		Student's Physical Address				
	Student's Mailing Address (If Different)					City, State, Zip	
	City, State, Zip						
<b>Mother/Guardian</b>	Who has Custody?: (Current Legal Documentation must be on file in the student's cumulative record.) <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____						
	Who Does the Student Live With? <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____						
<b>Father/Guardian</b>	Last Name: _____			First Name: _____			
	Home Address (If Different than student)			Work Phone: _____			
	City, State, Zip			Email: _____			
				Cell Phone: _____			
<b>Emergency Contacts</b>	Home Address (If Different than student)			Home Phone: _____			
	City, State, Zip						
	Last Name: _____			First Name: _____			
	Home Address (If Different than student)			Work Phone: _____			
City, State, Zip			Email: _____				
			Cell Phone: _____				
			Home Phone: _____				
<b>List the names of persons that may pick up and check out your student.</b>							
		<u>Name</u>			<u>Relationship</u>	<u>Phone Number</u>	
<b>Transportation</b>	On a TYPICAL day, how will your student arrive to school? <b>**Written Notice is needed for bus changes.</b>						
	<input type="checkbox"/> Car Dropoff <input type="checkbox"/> Walk <input type="checkbox"/> Ride School Bus AM Bus _____ ) <input type="checkbox"/> Drive (High School Student)						
	<input type="checkbox"/> Attend OFF-site before-care program (Program/Daycare: _____)						
	On a TYPICAL day, how will your student leave school? <b>**Written Notice is needed for bus changes.</b>						
<input type="checkbox"/> Car Dropoff <input type="checkbox"/> Walk <input type="checkbox"/> Ride School Bus PM Bus _____ ) <input type="checkbox"/> Drive (High School Student)							
<input type="checkbox"/> Attend OFF-site after-care program (Program/Daycare: _____)							
<input type="checkbox"/> Attend ON-site after school program (Program: _____)							
<b>Sibling(s)</b>	Please list any sibling(s) who currently attend Lafayette County Schools						
	First and Last Name		School		Grade Level		
<p><b>Military Activity:</b> A parent (defined as natural parent or appointed legal guardian) of this student is an Active Member of our Armed Forces.                  YES NO</p> <p style="text-align: center;"><b>Release of Information</b></p> <p>I agree that my student's name and photo may be released for the following:                  Press for Recognition Yes No Military Recruiters (high school only) Yes No Yearbook? Yes No Social Media Yes No</p>							

In the case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

Physician

Physician Name:	Physician's Office Name:
Physician's Office Number:	Physician's Office Address (City, State):

Medical Information

Please check or list any medical/mental health diagnoses/concerns which may effect the student's progress in school, sports, etc. (Check ALL that apply)

<input type="checkbox"/> Asthma	If checked, does the student use an inhaler?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily Meds
<input type="checkbox"/> Seizures	If checked, is the student on daily medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily Meds
<input type="checkbox"/> Diabetes	If checked, is the student insulin dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily Meds

Recent Illness/Hospitalization/Surgery (Describe):

Other Medical/Mental Health Diagnoses/Concerns (Describe):

Mild or  Severe Allergies. If Checked, please check the type below:

<input type="checkbox"/> Food/Environmental Specify:	<input type="checkbox"/> Insect Stings/Bites: Specify:	<input type="checkbox"/> Medicines/Drugs: Specify:	Allergies Require: <input type="checkbox"/> EpiPen <input type="checkbox"/> Benadryl Other:
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Does your child wear? Check all that apply.  Glasses  Contacts  Hearing Aids

The School Nurse will assist parents/guardians in obtaining medical help for their student(s). Health problems will be treated in a confidential manner. **You must notify the school nurse in writing if you do NOT want your student to receive basic first aid or to participate in one or more of the activities listed below.**

School Health Screenings are part of the School Health Services Plan. Nursing assessments and health counseling are a part of the scheduled screenings. A student may be referred by a parent or school staff at any time for the screenings listed below.

Grade K Hearing Vision	Grade 1 Hearing Vision Height Weight	Grade 3 Vision Height Weight	Grade 6 Same as Grade 1 Scoliosis	I give permission to DOH Lafayette School Health Services staff and Lafayette County School District staff to share medical information, as needed, in order to better serve my student. I understand individuals who share this information are told of the confidential nature. I am aware I am to call the School Nurse if my student's medical needs change.
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**I declare that the information on this form is true and correct. I will notify the school office immediately of any changes. A new form is needed for permanent moves.**

Notarization of this form is required by hospitals and physicians before they will render medical treatment to the student. There is a notary at each school for your convenience. This authorization shall remain in full force and is effective one fiscal year to the next. It may be revoked by written communication to the superintendent of schools of Lafayette County, Florida.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

State of Florida  
County of Lafayette

The foregoing instruction was acknowledged and signed before me the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Notary Public \_\_\_\_\_

My Commission Expires \_\_\_\_\_