

Lafayette County Emergency Medical Information

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.

Student Information	Last Name: _____		First: _____		Middle: _____	
	Date of Birth: / /		Gender: Male Female		Primary Phone: _____	
	Student's Physical Address		Student's Mailing Address (If Different)			
	City, State, Zip		City, State, Zip			
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 Gardian <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 Gardian <input type="checkbox"/> Other: _____						
Mother/Guardian	Last Name: _____			First Name: _____		
	Home Address (If Different than student)			Employer: _____		
	City, State, Zip			Work Phone: _____		
				Email: _____		
				Cell Phone: _____		
Home Phone: _____						
Father/Guardian	Last Name: _____			First Name: _____		
	Home Address (If Different than student)			Employer: _____		
	City, State, Zip			Work Phone: _____		
				Email: _____		
				Cell Phone: _____		
Home Phone: _____						
Emergency Contacts	List the names of persons that may pick up and check out your student.					
	Name		Relationship		Phone Number	
Transportation	On a TYPICAL day, how will your student arrive to school? **Written Notice is needed for bus changes.					
	<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? **Written Notice is needed for bus changes.					
	<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: _____)						
Sibling(s)	Please list any sibling(s) who currently attend a Lafayette County Schools					
	First and Last Name		School		Grade Level	
Military Activity:						
A parent (defined as natural parent or appointed legal guardian) of this child is an Active Member of our Armed Forces. Yes No						
Release of Information						
I agree that my child'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						

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Last Name: _____	First: _____	Middle: _____
If 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 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 child'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): _____		
<input type="checkbox"/> Mild or <input type="checkbox"/> 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: _____
Does your child wear? Check all that apply. <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> 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. <u>You must notify the school nurse in writing if you do NOT want your child to participate in one or more of the activities listed below.</u>			
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	Grade 1	Grade 3	Grade 6	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.
Hearing	Hearing	Same as Grade 1	Same as Grade 1	
Vision	Vision		Scoliosis	
	Height			
	Weight			

I declare that the information of 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 _____