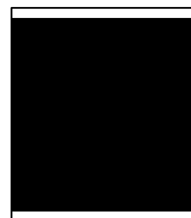
(OFFICE USE ONLY) ALERT ON FILE: ☐ CUSTODY ☐ MEDICAL ☐ OTHER: ______________________________

MUST BE FILLED OUT COMPLETELY AND ON FILE AT SCHOOL OFFICE

ST. JOHNS COUNTY SCHOOL DISTRICT

STUDENT EMERGENCY AND HEALTH INFORMATION

2013 - 2014



Student Last Name: ______________________________ **First Name:** ______________________________

Birth date: ____________________ Grade: ________ Teacher: ______________________________

Address: ______________________________City:______________________________Zip:______________

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: ______________ (Appropriate legal custody documentation must be on file in student's file.)

Mother: ☐ Natural Mother ☐ Step Mother ☐ Legal Guardian ☐ Other: ______________________________

Name: ______________________Home Ph: ______________ Cell #: __________ Work #:__________________

Father: ☐ Natural Father ☐ Step Father ☐ Legal Guardian ☐ Other: ______________________________

Name: ______________________Home Ph: ______________ Cell #: __________ Work #: __________________

Alert Now is a School-Wide Emergency Automated Phone System. Please list #'s to call, in order, in the event of an emergency:

1. ______________________ 2.______________________ 3.______________________

List all children in family in order of birth:

Name (First and Last)	Age	Grade	School

Students may receive State specified health services, vision, hearing, weight, BMI and scoliosis screening. Students may be exempted from any of these services if parent or guardian requests such exemption in writing.

Parent/Guardian Statement: I accept responsibility for notifying the school of any changes of home address or phone number or any change in health status of my child. In the event of serious illness or accident and the school cannot contact me, I give permission to have my child moved via ambulance or other conveyance to a hospital for immediate attention, and I assume responsibility for payments of same. In cas e of an accident or illness when immediate treatment is not needed, but when my child is unable to remain in school, I request to be contacted by the school. If I am unable to be reached, I request that one of the persons listed below be contacted to care for my child until I can be reached. These persons have permission to transport my child. I consent that appropriate information from my child's educational records will be shared with District health care partners as needed to provide and evaluate health services and that information from my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate need for access.

Signature of Parent or Guardian____ Date______________

Please Check Type of Transportation: ☐ **Parent Pick up** ☐ **Extended Day** ☐ **Day Care Pick Up** ☐ **Walk** ☐ **Bus #** __________

MUST BE FILLED OUT-Persons who will care for student in case neither parent can be reached (Only people listed may pick up your child):

Name______________________ **Relationship**______________ **Home #**__________ **Cell #**__________

Name______________________ **Relationship**______________ **Home #**__________ **Cell #**__________

Name______________________ **Relationship**______________ **Home #**__________ **Cell #**__________

Name______________________ **Relationship**______________ **Home #**__________ **Cell #**__________

Please check if student has a current problem with any of the following: ***Please note any medication student is taking.***

☐ **ADD/ADHD Medication**________ **When Given**________ ☐ **Allergies Specify**______________ **Medication**__________________

☐ **Asthma Medication**__________ **When Given**________ ☐ **Diabetes** ☐ **Heart Condition Describe:** __________________

☐ **Seizures - Type**______________________________ **Medication:**______________________________

☐ **Any other condition:** ____

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DOCTOR'S NAME______________________ **PHONE** ________________ ☐ ***Check if you add additional information on back of form***