

# 2024-25 Broward County Public Schools Student Emergency Contact Card

This form shall be updated every year

<b>Office Use Only</b>	Student #	Grade Level:	<input type="checkbox"/> Court Order	<input type="checkbox"/> Medical
	Date Enrolled:		<input type="checkbox"/> Special Needs	<input type="checkbox"/> Other
In the case of an emergency, it is imperative that the school be able to reach the student's parent (as defined below). Please fill in the information on both sides of this card carefully and accurately. Please use ink and print clearly. The names of both parents of a student (as defined in the Section 1000.21(6), Florida Statutes), the parent(s)/guardian(s) shall be listed on the emergency contact card as persons authorized to pick up the child from school except where a court order has revoked the parental rights, and a certified copy of such court order has been provided to the school office. Both parents shall designate on the Emergency Contact Card those persons authorized to pick up their child from school. No parents shall delete or in any way alter the names provided by the other parent on the Emergency Contact Card.				
<b>Student Information</b>	Last Name:		First:	Middle:
	Date of Birth:    /    /		Teacher (elementary school only):	
	Home Address:			
	Mailing Address (if different from above):			
	Check any that apply to student residents: <input type="checkbox"/> Medical <input type="checkbox"/> Court Order <input type="checkbox"/> Special needs <input type="checkbox"/> Other			
	Has student changed address since last registration? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Is there a court order on file that prevents a parent from having contact with the student? <input type="checkbox"/> No <input type="checkbox"/> Yes, contact school			
	Preferred Name(s)/Nickname(s):			
	All staff may refer to my child by the preferred name(s) or nickname(s) listed above on all unofficial documents and during school/district events.			
	Signature:		Date:	Relationship:
<b>Parent</b>	Last Name:		First:	Cell Phone:
	Home Address (if different from student):		City, State, Zip:	Home Phone:
	Employer:	Work Phone:	Parent Email:	
<b>Other Parent</b>	Last Name:		First:	Cell Phone:
	Home Address (if different from student):		City, State, Zip:	Home Phone:
	Employer:	Work Phone:	Parent Email:	
<b>Authorized Release/Contact</b>	Please list the names of persons to whom we may release your child or whom we may contact if we cannot reach you. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PERSONS LISTED BELOW. Both parents may designate on the Emergency Contact Card those persons authorized to pick their child up from school. In selecting someone to whom you authorize the release of your child, consider whether this person is prepared to handle any special medical needs required by your child. I/We hereby authorize contact with release of emergency related information, or release of the student to the following persons in the event of illness, evacuation, or other emergency that may occur while the student is in school.			
	Name:	Relationship:	Phone:	
I declare that the information on this card is true and correct. I will notify the school office immediately of any changes:				
Signature:		Date:	Relationship:	
The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by school staff on a need-to-know basis.				

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Student Last Name:

First:

Middle:

Grade Level:

<b>Health Services Consent</b>	<b>Health Screenings:</b> Students in screening grades may receive non-invasive health screenings for vision, hearing, scoliosis, and growth and development (BMI) pursuant to F.S. 381.0056(6)(e), unless the parent or guardian opts out in writing by checking "No" below:			
	Vision screening <input type="checkbox"/> Yes <input type="checkbox"/> No	Growth and Development screening (BMI) <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing screening <input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis screening <input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Signature:</b> _____		<b>Date:</b> _____	<b>Relationship:</b> _____
	<b>Consent for Health Care Services:</b> Care and treatment for illness and injury (i.e., School Clinic Visit, Basic First Aid). I give permission for my child to receive care: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Medical Information</b>	<b>Is your child currently diagnosed and followed by a healthcare provider for any of the following?</b> <input type="checkbox"/> My child does not have or no longer has any of the conditions listed below.			
	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies (Not life-threatening)	<input type="checkbox"/> Allergies (Life-threatening)	<input type="checkbox"/> Asthma (currently uses daily or emergency medication)
	<input type="checkbox"/> Autism	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiac conditions
	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Diabetes – Type 1	<input type="checkbox"/> Diabetes – Type 2	<input type="checkbox"/> Epilepsy/ Seizure disorders (NOT including febrile seizures)
<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Lupus	<input type="checkbox"/> Mental / behavioral health conditions	<input type="checkbox"/> Sickle cell disease (NOT Sickle cell trait)	
<input type="checkbox"/> Other (Specify): _____				
<b>Does your child require medication while at school?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you checked that your child has a current health condition (above), please complete the Health Condition Review Form. All conditions must have a provider diagnosis with the exception of 1) ADD/ADHD 2) Allergies (Non-life threatening) 3) Mental/behavioral health conditions 4) "Others" which can be based on documented parental report.				
Does your child wear glasses/contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your child wear hearing aid(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Health Insurance &amp; Providers</b>	<b>Please check the appropriate box:</b> <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Florida KidCare / Florida Healthy Kids <input type="checkbox"/> None			
	<b>If NONE, do we have your permission to forward the student's name, parent's name, contact information and current health insurance coverage status to Florida KidCare Insurance for health insurance screening to see if you may be eligible for health insurance coverage?</b> <input type="checkbox"/> Yes, please sign here: _____ <input type="checkbox"/> No			
	<b>Health Care Provider:</b> _____		<b>Phone:</b> _____	
<b>Release of Medical Information and Emergency</b>	I hereby authorize for my child's medical information, parental contact information, and other health information (collected from health services provided at school, including information stored electronically) to be shared with health department officials to address conditions of public health importance, including information to meet and to prepare for potential or confirmed health conditions. For students receiving health services from school or District staff and/or contracted partners, I also authorize the District to share my child's identifiable health information and related demographics with the Florida Department of Health to conduct monitoring to assure program compliance by the District and schools, and assess the delivery of services.			
	<b>Signature:</b> _____		<b>Date:</b> _____	
<b>Dismissal Information</b>	<b>Regular Dismissal Procedures: On a typical day, how will your child leave school?</b>			
	<input type="checkbox"/> Ride in a car	<input type="checkbox"/> Ride a school bus	<input type="checkbox"/> Ride public transportation	
	<input type="checkbox"/> Attend ON-site after-care program	<input type="checkbox"/> Attend OFF-site after-care program	<input type="checkbox"/> Walk or bike home	
	<b>Emergency Dismissal Procedures: In the event of a severe storm or other unscheduled emergency your child is instructed to:</b>			
<input type="checkbox"/> Walk home	<input type="checkbox"/> Ride a school bus as usual	<input type="checkbox"/> Ride public transportation		
<input type="checkbox"/> Ride home with parent only	<input type="checkbox"/> Ride home with person indicated on authorized contact list			
<b>Siblings and Home Language</b>	<b>Last Name:</b> _____	<b>First:</b> _____	<b>Grade Level:</b> _____	
	_____	_____	_____	
	_____	_____	_____	
	_____	_____	_____	
<b>Please list any other languages spoken at home:</b> _____				
<b>Survey Questions</b>	<b>Please assist us in understanding the needs of our school community by answering the following questions:</b>			
	<b>Does your child have access to a computer in your home?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Do you have home internet access?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Does your child have access to the internet on your home computer?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Do you have internet access outside your home?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please indicate the method of contact you prefer:</b> <input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email				