Broward County Public Schools

Student Emergency Contact Card

This form shall be updated every year

For Office Use Only:	□ *Medical*
School #:	□ *Court Order*
Student #:	□ *Special Needs*
Date Enrolled:	□ *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(5), Florida Statutes), the registering parent and the non-registering parent, of a student 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 parent shall delete or in any way alter the names provided by the other parent on the Emergency Contact Card.

Grade: Student Identification Number: Student:

Student Information

Last Name:	First:	Middle:
Teacher (elementary school only):	Gender: ☐ Male ☐ Female	Grade Level:
Home Address:	City, State, Zip:	Home Phone:
Mailing Address (If different from above):	City, State, Zip:	Student Cell Phone:
Date of Birth: / /	Student lives with:	Student Email:
Check any that apply to student residence: ☐ Medical ☐Court Order ☐Special needs ☐Other	Has student changed address since last registration? ☐ Yes ☐ No	Is there a court order on file that prevents a parent from having contact with the student? ☐ No ☐ Yes, contact school

Registering Parent

Last Name:	First:	Cell Phone:
Home Address (if different from student):	City, State, Zip:	Home Phone:
Employer:	Work Phone:	Parent email:

Other Parent

Last Name:	First:	Cell Phone:
Home Address (if different from student):	City, State, Zip:	Home Phone:
Employer:	Work Phone:	Parent email:

Authorized Release/Contact

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. 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:

Non-Registering Parent Authorized Release/Contact

This section may be completed only by the non-registering parent in order to designate additional persons who may pick up the student. The registering parent may not alter this section of this card. The non-registering parent may not alter any other portion of this card.

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:

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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.

Student Last Name: First: Middle:

Medication Information

Does your child take medication? ☐ Yes ☐ No	If your child requires medication at school, all medication sent to the school must be in the original prescription container with a current date and the child's name. Also, a "Medication/Treatment Authorization" form, must be completed and signed by the physician and the parent and must be on file at the school.	
Medication:	Dosage:	Hour(s) Given:

Health Insurance and Providers

Please check appropriate box: ☐ Family Health Insurance ☐ Florida Kid Care ☐ Florida Healthy Kids ☐ None

If NONE, do we have your permission to forward the parent's name and phone number to Florida Kid Care Insurance for health insurance screening to see if you may be eligible for health insurance coverage? If Yes, please sign here:

Physician:	Phone:
Dentist:	Phone:
Health Plan/Group name:	Phone:

Medical Information

Medical Conditions	Please check all that apply:	
☐ Asthma. If checked, uses inhaler?	☐ Yes ☐ No ☐ On daily medication	
☐ Seizures. If checked, on medication?	☐ Yes ☐ No	
☐ Diabetes. If checked, insulin dependent?	☐ Yes ☐ No	
☐ Movement limitations (specify):		
☐ Recent illness/hospitalization/surgery (describe:		
☐ Severe Allergies. If checked, specify Type: ☐ Food/environmental: ☐ Insect stings/bites: ☐ Medicines/Drugs:		Allergies require: ☐ EpiPen ☐ Benadryl ☐ Other:

Does your child wear glasses/contacts? ☐ Yes ☐No Does your child wear hearing aid(s)? ☐ Yes ☐ No

Release of Medical Information and Emergency Treatment

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 emergency personnel and 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 monitorings to assure program compliance by the District and schools, and assess the delivery of services.

Parent Signature: Date:

Medical and other information will be disclosed without consent from the parent/eligible student in case of health emergencies, as permissible by the Family Educational Rights and Privacy Act (FERPA). The school will call for emergency medical care as deemed necessary. Emergency transportation to a health care facility, as determined by paramedics, will be authorized.

Dismissal Information

Regular Dismissals Procedures. On a typical day, how will your child leave school?

☐ Ride in Car ☐ Ride School Bus ☐ Ride Public Transportation
☐ Attend ON-site after-care program ☐ Attend OFF-site after-care program ☐ Walk or Bike ride home

Emergency Dismissals Procedures. In the event of a severe storm or other unscheduled emergency your child is instructed to:

☐ Walk home ☐ Ride School Bus as usual ☐ Ride Public Transportation
☐ Ride home with parent only ☐ Ride home with person indicated on authorized contact list

Siblings and Home Language

Last Name:	First Name:	Grade level:

Please list any other languages spoken at home:

Survey Questions

Please assist us in understanding the needs of our school community by answering the following questions. Please check all that apply:

Does your child have access to a computer in your home?	☐ Yes ☐ No
Do you have home internet access?	☐ Yes ☐ No
Does you child have access to the internet on your home computer?	☐ Yes ☐ No
Do you have internet access outside your home?	☐ Yes ☐ No

Please indicate the method of contact you prefer: ☐ Phone call ☐ Text ☐ Email