

Citrus County School District
Emergency Information Form

PM Transportation	
<input type="checkbox"/> Bus # _____	<input type="checkbox"/> Day Care
<input type="checkbox"/> Parent Pickup	<input type="checkbox"/> Walker

School Use Only	
Teacher	
Student #	

STUDENT INFORMATION	School:	Grade:	Date:	
	Last Name		First Name	Middle Name
	Date of Birth (MM/DD/YY)	Birth Place (City/State)	Birth County	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Parent/Guardian student lives with:			
	Is there a court order on file that prevents a parent from having contact with the student? <input type="checkbox"/> Yes <input type="checkbox"/> No			

The names of **both parents** of a student, as defined in FS 1000.21(5) and including the registering parent and the non-registering parent, shall be listed on the Emergency Information Form 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. **BOTH** parents shall designate on this form those persons authorized to pick their child up from school in the event of an emergency. No parent shall delete or in any way alter the names provided by the other parent on this form.

FAMILY 1 (Student Primary Residence)	PARENT/GUARDIAN INFORMATION				
	Last Name		First Name	<input type="checkbox"/> Parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Other _____	
	Home Phone:	Cell Phone:	Work Phone:	Email:	
	Last Name		First Name	<input type="checkbox"/> Parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Other _____	
	Home Phone:	Cell Phone:	Work Phone:	Email:	
	Home Address		City	State	Zip Code
	Mailing Address (if different from Home Address):				
	Do you wish to receive school notifications via voice or text to your cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes', indicate Cell Phone: _____				
	EMERGENCY CONTACTS: Person(s) listed below may assume temporary care or responsibility of my child in case of emergency if I cannot be reached.				
	Name	Relationship	Emergency Phone 1	Emergency Phone 2	
Family 1 Completed By:		Signature:	Date:		

FAMILY 2	This section may be completed only by the Family 2 PARENT/GUARDIAN to designate additional persons authorized to pick up the student. The Family 1 Parent/Guardian may not alter this section. The Family 2 Parent/Guardian may not alter any other portion of this form.				
	Last Name		First Name	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian	
	Home Phone:	Cell Phone:	Work Phone:	Email:	
	Home Address		City	State	Zip Code
	EMERGENCY CONTACTS: Person(s) listed below may assume temporary care or responsibility of my child in case of emergency if I cannot be reached.				
	Name	Relationship	Emergency Phone 1	Emergency Phone 2	
	Family 2 Completed By:		Signature:	Date:	

SIBLINGS	Name	School	Grade	MEDIA RELEASE EXEMPTION Occasionally, media representatives visit schools to take photographs of various classroom activities. <u>If you do not want your child's picture released to the media during this school year</u> , please indicate below. <input type="checkbox"/> I do not want my child to have his/her picture published in the media. Parent Signature: _____

HEALTH INFORMATION

MEDICAID PERMISSION

I give permission for the Citrus County School District to request Medicaid eligibility reports and bill for Medicaid covered services provided to students as allowed by Federal and State guidelines. I give permission each time Medicaid is accessed for all reimbursable services, including health screenings and services referenced on the IEP. I further understand that I have the right to refuse release of any health information as provided by HIPAA and FERPA laws.

Signature: _____

Relationship to Student: _____

Date: _____

It is the responsibility of the parent/guardian to contact the School Nurse or Health Room Attendant directly *each school year* regarding medical interventions or treatments requested for their child.

ALLERGIES: Does your child have a physician's diagnosis of any of the following allergies? (check all that apply)

NON-LIFE THREATENING			LIFE THREATENING (Requires Medical Documentation)		
Food (List)	<input type="checkbox"/>	B01	Food (List)	<input type="checkbox"/>	A01
Bee/Insect	<input type="checkbox"/>	B02	Bee/Insect	<input type="checkbox"/>	A02
Environmental (List)	<input type="checkbox"/>	B03	Environmental (List)	<input type="checkbox"/>	A03
Animal	<input type="checkbox"/>	B04	Animal	<input type="checkbox"/>	A04
Shellfish	<input type="checkbox"/>	B05	Shellfish	<input type="checkbox"/>	A05
Peanuts	<input type="checkbox"/>	B06	Peanuts	<input type="checkbox"/>	A06
Dairy/Lactose	<input type="checkbox"/>	B07	Dairy/Lactose	<input type="checkbox"/>	A07
Latex	<input type="checkbox"/>	B08	Latex	<input type="checkbox"/>	A08
Other:	<input type="checkbox"/>	B09	Other:	<input type="checkbox"/>	A09
Describe past reactions:			Describe past reactions:		

Epi-pens must be provided by the parent/guardian. Does your child carry an epi-pen on their person? Yes** No **Child must have a 'Student Authorization to Carry Medication' form on file and signed by physician (forms are available on the district web page or at your child's school).

HEALTH CONDITIONS: Does your child have a physician's diagnosis of any of the following health conditions? YES NO (check all that apply)

ADD/ADHD (Physician Diagnosed)	<input type="checkbox"/>	D01	Muscular Dystrophy	<input type="checkbox"/>	D14
Autism	<input type="checkbox"/>	D02	Muscular/Skeletal	<input type="checkbox"/>	M14 / S14
Blood Disorder (Type)	<input type="checkbox"/>	D23	Neurological Concern	Mild / Severe <input type="checkbox"/>	M06 / S06
Cancer (Type)	<input type="checkbox"/>	D03	Nutritional Concern	Mild / Severe <input type="checkbox"/>	M07 / S07
Cerebral Palsy	<input type="checkbox"/>	D04	Orthopedic Concern	Mild / Severe <input type="checkbox"/>	M05 / S05
Circulatory Issues	<input type="checkbox"/>	M10 / S10	Osteogenesis Imperfecta	<input type="checkbox"/>	D15
Crohn's Disease	<input type="checkbox"/>	D05	Post-Traumatic Brain Injury	<input type="checkbox"/>	D16
Cystic Fibrosis	<input type="checkbox"/>	D06	Reflux	<input type="checkbox"/>	D17
Diabetes, Type 1	<input type="checkbox"/>	D24	Respiratory Condition (Regularly use Inhaler/Nebulizer)	<input type="checkbox"/>	S01
Diabetes, Type 2	<input type="checkbox"/>	D25	Respiratory Condition (Seasonal/Exercise/Cold Induced)	<input type="checkbox"/>	M01
Emotional Concerns	Mild / Severe <input type="checkbox"/>	M12 / S12	Scoliosis	<input type="checkbox"/>	D18
Endocrine Disorders	Mild / Severe <input type="checkbox"/>	M13 / S13	Seizure Disorder (Active seizure activity in past 5 years)	<input type="checkbox"/>	S02
Gastrointestinal Condition	Mild / Severe <input type="checkbox"/>	M03 / S03	Seizure Disorder (No seizure activity in past 5 years)	<input type="checkbox"/>	M02
Heart Condition	Mild / Severe <input type="checkbox"/>	M08 / S08	Sickle Cell Anemia	<input type="checkbox"/>	D19
Hemophilia	<input type="checkbox"/>	D09	Skin Disorder	Mild / Severe <input type="checkbox"/>	M11 / S11
Hernia (Existing)	<input type="checkbox"/>	D10	Spina Bifida	<input type="checkbox"/>	D20
High Blood Pressure (Physician Diagnosed)	<input type="checkbox"/>	D11	Ulcer (Type)	<input type="checkbox"/>	D21
Hypoglycemia (Physical Diagnosed)	<input type="checkbox"/>	D12	Urological Condition	Mild / Severe <input type="checkbox"/>	M09 / S09
Kidney Condition	Mild / Severe <input type="checkbox"/>	M04 / S04	Von Willebrands Disease	<input type="checkbox"/>	D22
Leukemia	<input type="checkbox"/>	D13	Other Condition:	<input type="checkbox"/>	O01
Lupus	<input type="checkbox"/>	D26			

IF YOU HAVE CHECKED ANY OF THE ABOVE HEALTH CONDITIONS, PLEASE CONTACT THE SCHOOL NURSE.

MEDICATIONS: List any prescription or over-the-counter medications the child takes on a regular basis.

DRUG NAME	HEALTH CONDITION	TO BE TAKEN AT SCHOOL?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL EQUIPMENT: Does your child use any specialized medical equipment? (check all that apply)

Catheterization	<input type="checkbox"/>	E02	Helmet	<input type="checkbox"/>	E12	Suction Machine	<input type="checkbox"/>	E13
Cochlear Implant	<input type="checkbox"/>	E19	Infusion Pump	<input type="checkbox"/>	E17	Tube Feed	<input type="checkbox"/>	E14
Crutches	<input type="checkbox"/>	E03	Nebulizer	<input type="checkbox"/>	E08	Walker	<input type="checkbox"/>	E15
Ear Tubes	<input type="checkbox"/>	E04	Orthopedic Device	<input type="checkbox"/>	E01	Wheelchair	<input type="checkbox"/>	E16
Existing Shunt	<input type="checkbox"/>	E05	Location:			Vaso Stimulator	<input type="checkbox"/>	E18
Glasses	<input type="checkbox"/>	E20	Oxygen	<input type="checkbox"/>	E09	Other (Specify Below):	<input type="checkbox"/>	E99
Glucometer	<input type="checkbox"/>	E06	PICC Line	<input type="checkbox"/>	E11			
Hearing Aids	<input type="checkbox"/>	E07	Pacemaker	<input type="checkbox"/>	E10			

Physician's Name: _____

Physician's Phone Number: _____

In the event of a medical emergency, if the school is unable to notify me or a temporary caregiver(s), I hereby authorize the Principal or Principal's designee to have my child, _____ (child's name), transported to a clinic or to a hospital for emergency treatment. I will be responsible for all costs incurred.

Signature: _____

Relationship to Student: _____

Date: _____