

Broward County Public Schools

Student Emergency Contact Card

This form shall be updated every year.

For office use only:

School # _____ Medical
 Student # _____ Court Order
 Date enrolled _____ Special Needs
 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 their child up from school. No parent shall delete or in any way alter the names provided by the other parent on the Emergency Contact Card.

Student: _____ Grade: _____

Student Identification Number: _____

Student: _____

Student

Registering Parent

Other Parent

Authorized Release/Contact

Non-registering Parent Authorized Release/Contact

Last	First	Middle		
Teacher (elementary school only)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade Level		
Home Address	City	State	Zip	Home Phone
Mailing Address (if different from above)	City	State	Zip	Date of Birth / /
Student lives with: _____ Check any that apply to student residence: <input type="checkbox"/> Medical <input type="checkbox"/> Special Needs <input type="checkbox"/> Court Order <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"/> Yes <input type="checkbox"/> No (If yes, contact school.)	

Last	First	Email		
Home Address	City	State	Zip	Home Phone
Employer	Work Phone		Cell Phone	

Last	First	Email		
Home Address	City	State	Zip	Home Phone
Employer	Work Phone		Cell Phone	

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: Is this person 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	Home Phone	Work or Cell 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 _____

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	Home Phone	Work or Cell 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 _____

Broward County Public Schools
Student Emergency Contact Card

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 Name

Last	First	Middle
Does your child take medication? <input type="checkbox"/> Yes <input type="checkbox"/> No		If your child requires medication at school, all medication sent to the school must be in 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

Medication	Dosage	Hour(s) Given

Health Insurance Information

Please check appropriate box:

<input type="checkbox"/> Family Health Insurance	<input type="checkbox"/> Florida Healthy Kids	<input type="checkbox"/> Florida Kid Care
<input type="checkbox"/> Medicaid # _____	<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Other _____

Vision and Hearing

Does your child wear contacts/glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child wear hearing aid(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Health Care Providers

Name	Phone Number
Physician	
Dentist	
Health Plan/Group Name	

Medical Conditions

Check all that apply:

<input type="checkbox"/> Asthma If checked, uses inhaler?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> On daily medication?
<input type="checkbox"/> Seizures If checked, on medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Diabetes If checked, insulin dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Movement Limitations _____		
<input type="checkbox"/> Recent illness/hospitalization/surgery (describe) _____		
<input type="checkbox"/> Other _____		
<input type="checkbox"/> Severe allergies? If checked, please specify:		
<input type="checkbox"/> Food/environmental	Allergies require:	
<input type="checkbox"/> Insect stings/bees	<input type="checkbox"/> EpiPen	
<input type="checkbox"/> Medicines/Drugs	<input type="checkbox"/> Benadryl	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

Release of Medical Information

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.

Emergency Treatment

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 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

<p align="center">REGULAR DISMISSAL PROCEDURES</p> <p>On a typical school day, how will your child leave school?</p> <input type="checkbox"/> Ride in car <input type="checkbox"/> Ride School Bus <input type="checkbox"/> Walk/bike home <input type="checkbox"/> Attend on-site after-care program <input type="checkbox"/> Ride public transportation <input type="checkbox"/> Attend off-site after-care program	<p align="center">EMERGENCY DISMISSAL PROCEDURES</p> <p>In the event of a severe storm or other unscheduled emergency dismissal your child is instructed to:</p> <input type="checkbox"/> Walk home <input type="checkbox"/> Ride school bus as usual <input type="checkbox"/> Ride public transportation <input type="checkbox"/> Ride home with friend as indicated on authorized contact list <input type="checkbox"/> Ride home with parent only
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Siblings and Home Language

Please list any siblings at our school	Please list any other languages spoken at home:												
<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%; padding: 5px;">Last Name</th> <th style="width:33%; padding: 5px;">First Name</th> <th style="width:33%; padding: 5px;">Grade Level</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Last Name	First Name	Grade Level										
Last Name	First Name	Grade Level											

Survey Questions

Please assist us in better 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have home internet access?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have access to the internet on your home computer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have internet access outside your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate the method of contact you prefer:	<input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Phone