(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

2014-2015

Office Use Only:

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 case 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 #** _____

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:** _____

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