Seaside School Consortium
Emergency Contact Information and Authorization for Release of Student from School

INSTRUCTIONS: Parent/Guardian/Surrogate please complete and return to Home Room Teacher Signature and date are required.

Student Legal Name (last, first, middle)

Date of Birth	Student #	Parent Email	Grade	Homeroom

Student Address: House number and street name, apartment #, city, state, zip code, housing development name (if applicable)

Emergency Contact Information and Authorization for Release of Student from School:

1. **PRINT all information.**
2. **INCLUDE EACH PARENT/GUARDIAN/SURROGATE ON THIS LIST. Circle the appropriate relationship to student.**
3. **List all contacts who may act on your behalf in case of sudden illness, accident, or emergency.**
4. **List names in the order they should be contacted.**
5. **The school will also use this information to determine who may pick up your student from school (non-emergency).**

Last Name	First Name	Relationship to Student	Daytime Contact Phone and	Emergency Contact?	Pick up from school (non-emergency)?
		Parent/Guardian/Surrogate		☐ YES ☐ NO	☐ YES ☐ NO
		Parent/Guardian/Surrogate		☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

Health Screenings: Students will receive non-invasive health screenings pursuant to Florida Statute 381.0056. Non-invasive screenings may include vision, hearing, scoliosis and growth and development (height/weight). These tests may be given individually or in groups. Parents or guardians, however, have the right to request an exemption in writing. If you **DO NOT** want your child to receive any or all of the screenings, write the words "Do Not Screen" in the boxes on the right that apply.

Vision: _____

Hearing: _____

Scoliosis: _____

Growth and Development: _____

Allergies Disclosure

Does the student have allergies? Yes ☐ No ☐

List any health conditions including but not limited to heart disease, diabetes, asthma, epilepsy, eye or ear problems:

Current medications, please list below:

General Media Release

As a parent or guardian of this student, I hereby consent to the use of photographs/video taken during the course of the school year for publicity, promotional and/or educational purposes (including publications, presentation or broadcast via newspaper, internet, or other media sources). I do this with full knowledge and consent and waive all claims for compensation for use, or for damages.

YES ☐ NO ☐

Doctor/ Primary Health Care Provider: Name: _____ Phone: _____ Fax: _____

I hereby give consent for my child to participate in the School Health Service Program and to receive nursing and emergency care at the school, if needed. Screening and/or evaluation for problems in the areas of vision, hearing, growth and development, nutrition, dental, scoliosis, communicable diseases, speech and language, or other non-invasive health screenings may be done as part of the program.

In the event of a serious accident or illness, I request that the school contact me. If I cannot be reached, I request designated school personnel to take or send my child to the hospital determined by Emergency Services personnel. I consent to be responsible for all expenses incurred. In case of an accident or illness where immediate medical treatment is not indicated, but where my child is unable to remain in school, I request the school contact me. If I cannot be reached, I request that one of the persons listed above be contacted to remove my child from school and to be responsible for his/her care. These persons listed have transportation and are immediately available to come to school.

The Florida Department of Health-Duval in conjunction with the Department of Education provides school health nursing services for Duval County Public Schools. I understand that all health-related information I provide to the school regarding my child will be shared between the two agencies as needed in the performance of their duties. I further understand that said information will be shared between agencies in compliance with state and federal laws governing student records and confidentiality requirements.

_____ _____ _____

PRINT *Parent/Guardian/Surrogate Name* **Parent/Guardian/Surrogate Signature** **Date**