DISTRICT SCHOOL BOARD OF PASCO COUNTY
GRADES 6 – 12 ACCESS AND EMERGENCY INFORMATION CARD

MIS Form #415
Rev. 4/17

☐ **Updated Info.** ____________

Student ______________________________ **Student #** __________ **DOB** __________ **Grade** ______
Last Name First Middle

Primary Phone ______________________

Home Address ______________________ **City** ______________ **Zip** ________

Parent/Guardian ______________________ **Parent/Guardian** ______________________

Cell Phone ______________________ **Cell Phone** ______________________

Email Address ______________________ **Email Address** ______________________

Employed By ______________________ **Employed By** ______________________

Phone At Work ______________________ **Phone At Work** ______________________

Person(s) who will care for child in case parent/guardian cannot be reached; these individuals may sign my child out (photo I.D. required):

Name ______________________ **Relationship** ____________ **Phone** ____________

Name ______________________ **Relationship** ____________ **Phone** ____________

Name ______________________ **Relationship** ____________ **Phone** ____________

Name ______________________ **Relationship** ____________ **Phone** ____________

First and last names of brothers/sisters attending Pasco County Schools ______________________

Person(s) who MAY NOT legally contact or remove my child from school (provide legal documentation) ______________________

List any medication(s) your child is currently taking (at home or school) ______________________
List all health problems and/or allergies (food, medication, sting, etc.) even if previously reported ______________________

Parent/guardian must notify school cafeteria of food allergies or special nutritional needs of student.

It is the parent/guardian's responsibility to keep the school updated with new information and contact numbers.

PARENTAL CONSENT ON BACK – SIGNATURE REQUIRED

Student ______________________ **Grade** ______

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The School District expects residence information submitted regarding students to be truthful and accurate, and District forms pertaining to residence and household membership shall be verified under penalties of perjury. Florida Statutes §837.06 provides that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree. Additionally, a person who knowingly makes a false declaration under penalties of perjury commits a felony of the third degree, pursuant to Florida Statute 92.525. Providing school officials false information regarding your residence when enrolling your child may result in your child being withdrawn and/or reassigned to the appropriate zoned school, and referral of the matter to law enforcement for possible criminal prosecution. Additionally, falsification of this information may result in the permanent revocation of your child's privilege to engage in extracurricular activities, including organized sports.
Parents/legal guardians are responsible for notifying the school principal if there is a change in residence or parental responsibility of the student within five (5) days, even if the parent thinks the student is still in the school's zone. Failure to give timely notice may result in a reassignment to the student's zoned school and/or loss of eligibility for athletics and other activities.

PARENTAL CONSENT

I hereby give my consent for my child to participate in the School Health Services Program. This means that my child will receive vision, hearing, dental, scoliosis, blood pressure, and height and weight screening at certain grade levels. In addition, the school nurse conducts classroom, individual, and small group presentations on health issues such as abstinence, substance abuse prevention, dating and relationship issues, birth control, and sexually transmitted diseases at certain grade levels. If I object to any of these health screenings or programs, I will notify the school in writing.

In case of accident or serious illness, I want to be contacted by the school. If the school is unable to reach me, I hereby authorize the school to contact the physician or dentist indicated below and to follow his/her instructions. If it is impossible to contact this physician or dentist, the school will take whatever actions are necessary to provide care and treatment for my child, and exchange medical information with the provider as necessary to support the continuity of care for my child. I agree to pay all expenses incurred by the handling of this emergency care. In case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain at school, I request that one of the persons listed on the reverse side of this form be contacted and requested to care for my child until I can be reached.

I authorize the District School Board of Pasco County to release and exchange my child's confidential information (e.g., student name, records, and information related to services provided) to agencies of the state of Florida which would allow the District to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's individualized educational plan (IEP), and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. I understand that my child will continue to receive services referenced on his/her IEP whether or not I give consent.

Physician's Name ______________________ Phone: ______________

Hospital Preference ______________________ Phone: ______________

Dentist's Name ______________________ Phone: ______________

My signature indicates my parental consent, understanding, and agreement.

______________________ ______________________ ____________
PRINT -- PARENT/GUARDIAN NAME **PARENT/GUARDIAN SIGNATURE** **DATE**