Alachua County Public Schools

Student Support Services

Emergency Contact Form

School Use Only

Student's Last Name:_____

Bus Number: a.m._____ p.m._____

School:_____

HR Teacher:_____

Student Information

Student Name:_____ Grade:_____
Last *First* *Middle Initial*

DOB *(MM/DD/YY):* _____/_____/_____

Gender: Male ☐ Female ☐

Race / Ethnicity: ☐ White (Non-Hispanic) ☐ Hispanic ☐ Multiracial
☐ Black(Non-Hispanic) ☐ Indian/Alaskan Native ☐ Asian/Pacific Islander

Residential 911 Address (Street No. and Name):_____ Apt./Lot #:_____

City/State/Zip:_____

Mailing Address (If different from residential):_____ Apt./Lot #:_____

City/State/Zip:_____

Parent / Guardian Information

Parent Guardian 1

Full Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City/State/Zip:_____ Ethnicity:_____ Gender:_____

Employer:_____ Work Phone:_____

In case of a school emergency, do you want to receive text alerts? ☐ Yes ☐ No
(The number provided must be capable of receiving text and charges from your service provider may apply)

Text Alert Phone Number:_____ Email:_____

Parent Code (check one): ☐ Parent (P) ☐ Other (O)
☐ Legal Guardian (G) ☐ Guardian Ad Litem (A)
☐ Surrogate (S) ☐ No Parent/Guardian Required (N)

Parent Guardian 1

Full Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City/State/Zip:_____ Ethnicity:_____ Gender:_____

Employer:_____ Work Phone:_____

In case of a school emergency, do you want to receive text alerts? ☐ Yes ☐ No
(The number provided must be capable of receiving text and charges from your service provider may apply)

Text Alert Phone Number:_____ Email:_____

Parent Code (check one): ☐ Parent (P) ☐ Other (O)
☐ Legal Guardian (G) ☐ Guardian Ad Litem (A)
☐ Surrogate (S) ☐ No Parent/Guardian Required (N)

- Please Continue to Page Two -

Emergency Contact Form
Page Two

Medical Information

Physician's Name:_____ Phone:_____

Immunization Status:_____ Corrective Lenses: Yes ☐ No ☐ Hearing Aid: Yes ☐ No ☐

Allergies (List allergies students may have):_____

Health Issues:_____

Medical Statement:_____

Is Student Taking Medications Regularly? Yes ☐ No ☐

If Yes, Please List:_____

Hospital Preference (See Medical Emergency Release Below):_____

Medicaid: Yes ☐ No ☐ School Insurance: Yes ☐ No ☐ Other Insurance: Yes ☐ No ☐

Additional Contact Information

Person to Contact if Parent Cannot be Reached:

_____ Phone:_____

Gender_____ Ethnicity:_____

After School Care Name:_____ Phone:_____

Foster Care Agency Worker (if applicable):_____ Phone:_____

Name(s) of Brothers and Sisters Attending This School:

_____

****

Medical / Emergency Release

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

In the event of 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 specified above. In some circumstances, Emergency Services personnel may determine that another hospital should receive my child. 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.

Parent Signature:_____ Date:_____

I give permission to Alachua County Public Schools each time Medicaid is accessed to release and exchange personal identifiable information with the Medicaid fiscal agent for the purpose of determining Medicaid eligibility status and billing for reimbursable services referenced on the IEP.

Parent Signature:_____ Date:_____