



ORANGE COUNTY PUBLIC SCHOOLS
Orlando, Florida
Emergency Student Information Form

STUDENT INFORMATION

Last Name (Legal)		Generation (i.e. Jr., II)	First Name (Legal)		Middle Name (Legal)
Preferred Name			Legal Alert (example: custody, restraining order, etc.) *Please provide supporting documentation*		
Student Number	Student SSN #	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Birth Date	Home Phone
Residential Address*		Apt #	City		Zip Code
Mailing Address			City		Zip Code
Do you need communications in a language other than English?					
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Spanish <input type="checkbox"/>	Haitian Creole <input type="checkbox"/>	French <input type="checkbox"/>	Vietnamese <input type="checkbox"/> Portuguese <input type="checkbox"/>

PHYSICIAN INFORMATION

Doctor's Name	Dentist's Name		Preferred Hospital
Doctor's Phone Number	Dentist's Phone Number		Currently Under Physician's Care Yes <input type="checkbox"/> No <input type="checkbox"/>
Insurance (Medicaid, etc.)	Insurance Phone Number	Policy #	Group #

Medicine Currently Taking			
Medical History			
Allergies			

PARENT/GUARDIAN INFORMATION (Please list parent/guardian in order of contact priority.)

Last Name	First Name		Relationship	Pick up Yes <input type="checkbox"/> No <input type="checkbox"/>
Residential Address		Apt #	City	Zip Code
Home Phone	Cell Phone	Employer		Business Phone

Last Name	First Name		Relationship	Pick up Yes <input type="checkbox"/> No <input type="checkbox"/>
Residential Address		Apt #	City	Zip Code
Home Phone	Cell Phone	Employer		Business Phone

ADDITIONAL CONTACTS ON THE NEXT PAGE

*Proof of address must be presented to the school in order for the address to be officially changed in the system.

Student Name: _____

Student Number: _____

ADDITIONAL CONTACTS

Name	Relationship	Home Phone	Cell Phone	Business Phone	Pick up
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>

SCHOOL HEALTH SERVICES

I hereby give my consent for this child to participate in the School Health Services Program. My child will receive emergency care in school, and health appraisals including vision, hearing, growth and development.

In the event of a serious accident or illness and I cannot be reached, I hereby authorize the school to contact the physician or dentist and for those professionals to provide protected health information.

In the event of an EMERGENCY, I understand that the school will access the **911** emergency medical system immediately. To expedite care I give my permission for school personnel to provide medical information to the responding emergency team to initiate treatment, and transport to an appropriate facility. I give my permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I request to be notified of my child's condition and admission as soon as possible. If I cannot be reached, I request that the admitting facility notify one of the other persons listed above of my child's condition and admission. I agree to be financially responsible for my child's total treatment, and transport.

I have reviewed the above information and have made corrections as needed.

Permission To:
 Call Doctor Call Ambulance Treat

(This form is effective for one year from the date signed)

Parent/Guardian: _____

Date: _____