

**THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA
EMERGENCY CONTACT INFORMATION**

Form# 136
Rev. 5/27/20

Student _____ Birthdate _____ Male Female Grade: _____
Last name First Middle

Extended Day Yes No Bus/Route Number: _____ Subdivision: _____ Teacher: _____

Mailing Address: _____ City: _____ Zip: _____

Street Address (if different from above): _____

Parent/Guardian 1's Name _____ Phone1 _____ Phone2 _____

E-mail: _____

Parent/Guardian 2's Name _____ Phone1 _____ Phone2 _____

E-mail: _____

Student's Best phone# _____ E-mail: _____

Automated Outbound Notification System

This system will notify you of school and district news using the primary contact number that you designate below and the email above.

Outbound calls 1st contact # _____ Outbound calls 2nd contact #: _____

Automated Emergency Notification System- This notifies you in an emergency by calling/texting both of the numbers that you list below.

Emergency calls 1st contact # _____ Emergency calls 2nd contact #: _____

Emergency Contact Information. If the parent/guardian is not available the person(s) listed below, after identification is verified, are the only person(s) student will be released to

Name _____ Phone1 _____ Phone2 _____ Relationship _____

Name _____ Phone1 _____ Phone2 _____ Relationship _____

Name _____ Phone1 _____ Phone2 _____ Relationship _____

Student Medical Information and Parent/Guardian Consent for Screenings and Emergency Medical Treatment

Physician(s) Name _____ Office phone # _____

Does your child have a Chronic Health condition (physical or mental) or food allergy? Yes No Medicaid eligible? Yes No

If yes, what is the physician's diagnosis? _____ Allergic reactions:

No Yes (describe): _____

If child has a food allergy and needs a food substitute, please contact food service for procedures.

What medication is your child prescribed? _____

What medications will be dispensed at school? _____

ALL MEDICATIONS TAKEN AT SCHOOL ARE REQUIRED TO HAVE A COMPLETED FORM #135 IN THE SCHOOL CLINIC.

Check all of the categories below that apply to your child:

Vision Aid: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts	Does your child have a hearing loss: <input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Handicap (describe): _____	If there is a loss is it:
	<input type="checkbox"/> Unilateral(One ear) on the <input type="checkbox"/> Right <input type="checkbox"/> Left
	<input type="checkbox"/> Bilateral (both ears) Does your child wear a hearing aid(s) <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both

I give my consent for my child to take part in the School Health Services Program that may include:

(NOTE: The absence of checking implies permission)

Vision Screening <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Screening, Specific Observations <input type="checkbox"/> Yes <input type="checkbox"/> No	Educational Screening, Observations <input type="checkbox"/> Yes <input type="checkbox"/> No
Speech/Hearing Screening <input type="checkbox"/> Yes <input type="checkbox"/> No	Oral Temperature <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health Screening, Specific <input type="checkbox"/> Yes <input type="checkbox"/> No
Scoliosis Screening <input type="checkbox"/> Yes <input type="checkbox"/> No	Body Mass Index <input type="checkbox"/> Yes <input type="checkbox"/> No	Nutrition Screening/Diet History <input type="checkbox"/> Yes <input type="checkbox"/> No

In case of accident or serious illness, I ask that the school contact me. If the school cannot reach me, the school is to contact and follow the instructions of the physician(s) listed. If the school cannot contact this physician, the school may do whatever is needed to provide care and treatment for my child. If any person listed on this consent form cannot be reached, school personnel have permission to transport the child to the nearest emergency room. I consent to emergency care provided in the school. In case of an accident or illness when immediate treatment of my child is not needed but where he/she cannot remain at school, I ask that the school contact me to arrange transportation for my child. If the school is unable to contact either me or my spouse, please contact one of the persons listed on the other side to care for my child until I can be reached. The information provided on this form is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____