Form# 1189
Rev. 5/9/12

THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA

Confidential Emergency Information

Please Print

Please Place Photo Here

The following information must be provided by parent/guardian for students requiring special transportation

Student Name:	Birth Date:	
Address:	Phone:	
City	State	Zip:

A. IDENTIFYING INFORMATION

Height	Weight	Hair Color	Eye Color	Visually Impaired □ YES □ NO	Hearing Impaired □ YES □ NO	Verbal □ YES □ NO	Language Spoken/Understood
Physical Handicap □ YES □ NO	If yes, please describe the physical handicap:						□ Ambulatory □ Non-ambulatory
Intellectual Disability: □ YES □ NO	Emotional Behavior Present □ YES □ NO	Severe: □ YES □ NO	Can child be dropped off without parental supervision? □ YES □ NO				
Alternate Provisions – Name:	Address:	Daytime Phone:					
Special Considerations:							

B. FAMILY INFORMATION

Name: □ Parent □ Guardian	Address:	Daytime Phone:

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C. EMERGENCY MEDICAL INFORMATION

Student's Doctor:	Phone:
Hospital Preference:	Phone:
Should an agency be contacted? □ YES □ NO	Agency:

D. MEDICAL HISTORY

Does the student have seizures? □ YES □ NO	If yes, describe symptoms:
Does student take medication? □ YES □ NO	List medications:
Is student allergic to food or medication? □ YES □ NO	If yes, list:
Does student have a bleeding disorder? □ YES □ NO	Additional Information:
List other disease or condition that we should know about to best serve the student (example: diabetes)	

E. CONSENT (please print names)

I, _____ father, mother or legal guardian of _____,
In the event of accident, injury or serious illness to him/her, do voluntarily hereby give consent to and authorize Martin County Schools to secure medical aid or transportation to a medical facility. I understand that neither Martin County Schools nor the individual responsible for obtaining medical aid will be responsible for expense incurred.

_____ _____

Signature of Parent/Legal Guardian **Date**