THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA AND
FLORIDA DEPARTMENT OF HEALTH IN SARASOTA COUNTY
SCHOOL HEALTH SERVICES
1960 LANDINGS BOULEVARD, SARASOTA, FL 34231
PHONE (941) 927-9000

HEALTH EMERGENCY INFORMATION FOR SCHOOL YEAR _____

Instructions: Complete and sign this form and return it to the school office.

Student Name (Print) _____
Last First Middle

DOB _____ Student No. _____ Grade _____

Current School _____

Family Physician Name _____ Physician Phone Number _____

Allergies (Specify) _____

Significant Health History _____

_____

_____

_____

_____

The Health Services Plan makes provision for health record, nursing consultation, emergency care treatment, and non-invasive screening (i.e., hearing, vision, scoliosis, height and weight measurement). Any parent wishing to opt their child out of a screening must do so in writing. Temperature screening will be done if deemed necessary. A limited number of topical medications, as have been approved by school district policy and listed in the School Health Services Manual, may be used in the health room.

In case of serious illness or injury where immediate care is needed, the school or its representative has my permission to contact the appropriate emergency medical service. The emergency medical service has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for emergency treatment cost.

In the case of an accident or illness where immediate treatment of my child is not indicated, but where my child is unable to remain at school, I request that the school contact me or one of the other persons listed on the Student Registration Form to arrange transportation for my child. In the event no person designated on the Student Registration Form is available, emergency medical services may be contacted for further assessment and possible transport and treatment. I understand that I must notify the school if there are any changes in this health emergency information.

I understand that certain educational records of my child will be shared with the District's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such records.

_____ _____ _____
Parent/Guardian Name (Print) Parent/Guardian Signature Date