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

HEALTH EMERGENCY INFORMATION 2016-2017 PARENTAL CONSENT

Student Name _____ DOB _____ Sex _____
Last First Middle

Current School _____ Grade (2016-2017 school year) _____

Teacher _____ (Do not complete the shaded area – school personnel will fill in)

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

Medication Allergies (Specify) _____ Allergies (Specify) _____

Other Health Concerns/Special Instructions/Required Medications, etc. _____

_____

_____

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. Parent/guardian has the responsibility of listing any allergies on the top part of this form.

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 (s)he is unable to remain at school, I request that the school contact me or my designee to arrange transportation for my child. If the school is unable to contact me, I request that one of the other persons listed on the Student Registration Form be contacted and requested to care 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 _____