



DISTRICT SCHOOL BOARD OF PASCO COUNTY
GRADES 6 - 12 ACCESS AND EMERGENCY INFORMATION CARD

MIS Form #415
Rev. 4/17

Updated Info.

Student Last Name First Middle Student # DOB Grade

Primary Phone

Home Address City Zip

Parent/Guardian Parent/Guardian

Cell Phone Cell Phone

Email Address Email Address

Employed By Employed By

Phone At Work Phone At Work

Person(s) who will care for child in case parent/guardian cannot be reached; these individuals may sign my child out (photo I.D. required):

Name Relationship Phone

Name Relationship Phone

Name Relationship Phone

Name Relationship Phone

First and last names of brothers/sisters attending Pasco County Schools

Person(s) who MAY NOT legally contact or remove my child from school (provide legal documentation)

List any medication(s) your child is currently taking (at home or school)

List all health problems and/or allergies (food, medication, sting, etc.) even if previously reported

Parent/guardian must notify school cafeteria of food allergies or special nutritional needs of student.

It is the parent/guardian's responsibility to keep the school updated with new information and contact numbers.

PARENTAL CONSENT ON BACK - SIGNATURE REQUIRED

Student Grade

MIS Form #415
Rev. 4/17 Back

The School District expects residence information submitted regarding students to be truthful and accurate, and District forms pertaining to residence and household membership shall be verified under penalties of perjury.

Parents/legal guardians are responsible for notifying the school principal if there is a change in residence or parental responsibility of the student within five (5) days, even if the parent thinks the student is still in the school's zone.

PARENTAL CONSENT

I hereby give my consent for my child to participate in the School Health Services Program. This means that my child will receive vision, hearing, dental, scoliosis, blood pressure, and height and weight screening at certain grade levels.

In case of accident or serious illness, I want to be contacted by the school. If the school is unable to reach me, I hereby authorize the school to contact the physician or dentist indicated below and to follow his/her instructions.

I authorize the District School Board of Pasco County to release and exchange my child's confidential information (e.g., student name, records, and information related to services provided) to agencies of the state of Florida which would allow the District to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's individualized educational plan (IEP), and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school.

Physician's Name Phone:

Hospital Preference Phone:

Dentist's Name Phone:

My signature indicates my parental consent, understanding, and agreement.

PRINT -- PARENT/GUARDIAN NAME

PARENT/GUARDIAN SIGNATURE

DATE