Alachua County Public Schools

Emergency Contact Form

Student Information

Name of Student (Last)	(First)	(Middle)	Grade	SCHOOL USE ONLY
				_____ Student Last Name

DOB (MM/DD/YY) _____/_____/_____

Gender: Male ☐ Female ☐

Race / Ethnicity
- ☐ Asian/Pacific Islander
- ☐ Black, Non-Hispanic
- ☐ Hispanic
- ☐ Indian / Alaskan Native
- ☐ Multiracial
- ☐ White, Non Hispanic

Fl Stu. No._____
Bus Number am_____ pm _____
School _____
HR Teacher _____

Residential 911 Address (Street No. and Name)	Apt. / Lot #	City	State	Zip
Mailing Address (If different from residential address)	**Apt. / Lot #**	**City**	**State**	**Zip**

Parent / Guardian Information

Parent Guardian 1(Last) (First) (Middle)

Home Phone _____
Cell Phone _____

Parent Code (check one)
- ☐ P - Parent
- ☐ O - Other
- ☐ G - Legal Guardian
- ☐ S - Surrogate
- ☐ A - Guardian Ad Litem
- ☐ N - No Parent/ Guardian Required

Address	City / State / Zip		
Employer Work Phone	Parent #1 Ethnicity	Parent #1 Gender	

In the case of a school emergency, do you want to receive text alerts? ☐ Yes ☐ No

Phone No: _____
The number must be capable of receiving texts and charges from your service provider may apply.

Email Address: _____

Parent Guardian 2(Last) (First) (Middle)

Home Phone _____
Cell Phone _____

Parent Code (check one)
- ☐ P - Parent
- ☐ O - Other
- ☐ G - Legal Guardian
- ☐ S - Surrogate
- ☐ A - Guardian Ad Litem
- ☐ N - No Parent/ Guardian Required

Address	City / State / Zip		
Employer Work Phone	Parent #2 Ethnicity	Parent #2 Gender	

In the case of a school emergency, do you want to receive text alerts? ☐ Yes ☐ No

Phone No: _____
The number must be capable of receiving texts and charges from your service provider may apply.

Email Address: _____

Medical Information

Physician's Name	Phone	Immunization Status	Corrective Lenses ☐ Yes ☐ No	Hearing Aid ☐ Yes ☐ No
Allergies (List allergies students may have)	**Health Issues**			
Medical Statement				
Is Student Taking Medications Regularly? ☐ Yes ☐ No	If Yes, Please List			
Hospital Preference (See Medical Emergency Release Below)		Medicaid ☐ Yes ☐ No	School Insurance ☐ Yes ☐ No	Other Insurance ☐ Yes ☐ No

Additional Contact Information

Person to Contact if Parent Cannot be Reached	Phone	Gender	Ethnicity

After School Care Name	Phone	Student in Foster Care (Agency Worker)	Phone

Name(s) of Brothers and Sisters Attending This School

MEDICAL / EMERGENCY RELEASE

I hereby give consent for my child to participate in the School Health Service Program and to receive emergency care at the school, if needed. Screening and evaluation for problems in areas of vision, hearing, growth and development, nutrition, dental, scoliosis, communicable diseases, blood pressure, speech and language, or other non-invasive health screenings may be done as part of the program.

In the event of serious accident or illness, I request that the school contact me. If I cannot be reached, I request designated school personnel to take or send my child to the hospital specified above. In some circumstances, Emergency Services personnel may determine that another hospital should receive my child. I consent to be responsible for all expenses incurred. In case of an accident or illness where immediate medical treatment is not indicated, but where my child is unable to remain in school, I request the school contact me. If I cannot be reached, I request that one of the persons listed above be contacted to remove my child from school and to be responsible for his/her care. These persons listed have transportation and are immediately available to come to school.

Signature _____ Date _____
Parent, Guardian or Agency

I give permission to Alachua County Public Schools each time Medicaid is accessed to release and exchange personal identifiable information with the Medicaid fiscal agent for the purpose of determining Medicaid eligibility status and billing for reimbursable services referenced on the IEP.

Signature _____ Date _____
Parent, Guardian or Agency