# ORANGE COUNTY PUBLIC SCHOOLS

Orlando, Florida

**Emergency Student Information Form**

**School Year 20__-20__**

Student Number: _____

**STUDENT INFORMATION**

| Last Name (Legal) | Generation (i.e. Jr., II) | First Name (Legal) | Middle Name (Legal) |
|---|---|---|---|
| | | | |

| Preferred Name | Legal Documentation (example: custody, restraining order, etc.) If there is no Legal Alert: Enter "N/A" Please provide supporting documentation |
|---|---|
| | |

| Parent/Guardian - Primary E-mail Address | Gender | Birth Date | Primary Phone |
|---|---|---|---|
| | ☐ Male ☐ Female | | |

| Address Domicile | Apt # | City | Zip Code |
|---|---|---|---|
| | | | |

| Mailing Address | Apt # | City | Zip Code |
|---|---|---|---|
| | | | |

**Do you need communication in a language other than English?**

☐ No ☐ Yes ☐ Spanish ☐ French ☐ Portuguese ☐ Haitian Creole ☐ Vietnamese

**PHYSICIAN INFORMATION**

| Doctor's Name | Dentist's Name | Preferred Hospital |
|---|---|---|
| | | |

| Doctor's Phone Number | Dentist's Phone Number | Currently Under Physician's Care |
|---|---|---|
| | | ☐ No ☐ Yes |

| Insurance | Insurance Phone Number | Policy # | Group # |
|---|---|---|---|
| | | | |

| Medicine Currently Taking |
|---|
| |
| **Medical History** |
| |
| **Allergies** |
| |

**PARENT/GUARDIAN INFORMATION (Please list parent/guardian in order of contact priority.)**

| Last Name | First Name | Relationship | Pick up |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| **Domicile Address** | **Apt #** | **City** | **Zip Code** |
| | | | |
| **Home Phone** | **Cell Phone** | **Employer** | **Business Phone** |
| | | | |

| Last Name | First Name | Relationship | Pick up |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| **Domicile Address** | **Apt #** | **City** | **Zip Code** |
| | | | |
| **Home Phone** | **Cell Phone** | **Employer** | **Business Phone** |
| | | | |

**ADDITIONAL CONTACTS ON THE NEXT PAGE**

****Proof of address must be presented to the school Registration Office in order for the address to be officially changed in the system.**

Student Name:_____ Student Number:_____

**ADDITIONAL CONTACTS**

| Last Name | First Name | Relationship | Contact Phone | Custody | Pick up |
|---|---|---|---|---|---|
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |

**SCHOOL HEALTH SERVICES**

I hereby give my consent for this child to participate in the School Health Services Program. My child will receive emergency care in school, and health appraisals including vision, hearing, growth and development.

If, upon administering a vision screening through the school or any other OCPS program, my child is determined to have a need for a follow-up vision examination and if my child is eligible or otherwise financially qualified, I hereby authorize for OCPS or a designated third party to provide a no-cost comprehensive vision examination by a licensed optometrist which may include dilation, refraction, and glasses if prescribed.

In the event of an EMERGENCY, I understand that the school will access the **911** emergency medical system immediately. To expedite care I give my permission for school personnel to provide medical information to the responding emergency team to initiate treatment, and transport to an appropriate facility. I give my permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I request to be notified of my child's condition and admission as soon as possible. If I cannot be reached, I request that the admitting facility notify one of the other persons listed above of my child's condition and admission. I agree to be financially responsible for my child's total treatment, and transport.

(This form is effective for one year from the date signed)

☐ I authorize the School District of Orange County, Florida to release and exchange my child's confidential information to agencies of the State of Florida which would allow Orange County Public Schools to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's IEP and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. I understand that my child will continue to receive services referenced on his/her IEP whether or not I give consent. Please take the student's Social Security card to the school Registrar to finalize authorization.

**Parent/Guardian:** _____ **Date:** _____

*The School Board of Orange County, Florida is authorized to collect social security numbers ("SSN") of students as set forth in Sections 1008.386 and 119.071 (5) (a) 6, Florida Statutes.The provision of a student's SSN on the enrollment form is optional and is not required as a condition for enrollment within the District. Any SSN provided in connection with enrollment will only be used for research, reporting and recording purposes. The collection of the SSN shall not be used for immigration enforcement. Providing the student's SSN to the School Board of Orange County, Florida for these purposes means that you consent to the use of the student's SSN in the manner described.