EMERGENCY CARD

Classical Preparatory School
Summer Academy 2021
Access and Emergency Information Card

Student_____ **Student #**_____ **DOB** _____ **Grade** ____ **Gender** _____
Last Name **First** **Middle Initial**

Primary Phone_____ **Date Card Completed** _____

Home Address _____ City_____ Zip_____

Parent/Guardian _____ **Parent/Guardian**_____
Home Phone _____ Home Phone _____
Cell Phone _____ Cell Phone _____
Email Address _____ Email Address _____
Employed By _____ Employed By _____
Work Phone _____ Work Phone _____

Person(s) who will care for the child in case parent/guardian cannot be reached; these individuals may sign the child out (photo I.D. required)
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
First and Last name of brothers/sisters attending Summer Academy_____
Person(s) who **MAY NOT** legally contact or remove my child (provide legal documentation) _____
_____
List any medication(s) your child is currently taking at home _____
List any medication(s) your child is currently taking at school _____
List all health problems and or allergies (food, medication, sting, etc.) even if previously reported _____
_____
_____
Severity of Allergy symptoms _____
Hospital Preference _____ Hospital Address _____
Physician's Name _____ Physician's Number _____
Dentist's Name _____ Dentist's Number _____

Parent/Guardian must notify the school of the student's food allergies.
It is the parent/guardian's responsibility to keep the school updated with new information and contact numbers.

PARENTAL CONSENT- SIGNATURE REQUIRED

In Case of an 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 above and to follow his/her instructions. If it is impossible to contact a physician or dentist, the school will take whatever actions necessary to provide care and treatment for my child, and exchange medical information with the provider as necessary to support continuity of care for my child. I agree to pay all expenses incurred by the handling of this emergency care. In case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain in school, I request that one of the persons listed on this form be contacted and requested to care for my child until I can be reached.

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 be allowed the District to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services reference 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. I understand that my child will continue to receive service referenced in his/her IEP whether or not I give consent.
My Signature indicates my parental consent, understanding, and agreement.

_____ _____ _____
PRINT- PARENT/GUARDIAN NAME **PARENT/GUARDIAN SIGNATURE** **DATE**

REF: Pasco County School District
Rev. 8.5.2019