

FLORIDA UNION FREE SCHOOL DISTRICT
Student Medical Emergency Form

Student ID: _____

School: _____

Student Name: _____

DOB: _____

Home Address: _____ City: _____

Father's Name _____ Primary Telephone number _____ (____) _____
Secondary Telephone # _____

Mother's Name _____ Primary Telephone number _____ (____) _____
Secondary Telephone # _____

Home Phone: (____) _____ e-mail address/Primary guardian _____

Please complete the information below to assist us in knowing current information about your child. (This confidential information will be shared with the school personnel deemed appropriate by the health professional in your child's building on an as needed basis.)

Known Allergies: _____

Current Medications: _____

Other Medical Conditions: _____

Emergency Contact Information

In the event of an emergency, the district will follow the sequence below in contacting family members.

First Contact

Name: _____ Primary Phone: _____ Secondary Phone: _____

Relationship: _____ Primary Phone: _____ Secondary Phone: _____

Second Contact

Name: _____ Primary Phone: _____ Secondary Phone: _____

Relationship: _____ Primary Phone: _____ Secondary Phone: _____

Third Contact

Name: _____ Primary Phone: _____ Secondary Phone: _____

Relationship: _____ Primary Phone: _____ Secondary Phone: _____

Medical Professional Information

Healthcare Provider: _____ Telephone #: (____) _____

Family Dentist: _____ Telephone #: (____) _____

Hospital of Choice: _____ Telephone #: (____) _____

If the School District is unable to reach the above Emergency Contacts in the order listed, I do hereby authorize the School District to call the family Healthcare Provider listed above. In the event the family Healthcare provider cannot be reached, I do authorize the School District to transport my child, by ambulance if necessary, to a hospital emergency room, if, in the judgment of the School District, such emergency treatment seems warranted. I understand that the district does not assume responsibility for medical fees or expenses incurred. This authorization also includes authority to release pertinent medical records in the event of a medical emergency.

Parent/Guardian Signature: _____ Date: _____