Consent

Note: This form is given to ALL students at the start of school each year.

# STUDENT DATA AND EMERGENCY CARD

School Board of Levy County

Full Name of Student

| (Last) | (First) | (Middle) | Birth Date: | Grade: Teacher: |
|---|---|---|---|---|
| | | | | |

| Male:_____ Female:_____ | Bus Driver Name | Bus Number |
|---|---|---|
| | | |

**Child lives with:**
(Circle all that apply) Mother Father Stepmother Stepfather Legal Guardian (Paperwork is on file at the school)

In order to accurately assign Skyward user names and passwords we need to ask for contact information in the following manner. As the parent with internet access you are able to access your child's educational electronic record. A family user name and password can be issued. The good news is if you are estranged/divorced from your spouse (your child's other parent) we are able to set up two families so you two do not have to share user name and password information. Therefore, as you fill out the information below keep this in mind –

- Family #1 should be the parent/guardian the child lives with the majority of the time.
- Family #2 should be the other parent.
- If you have provided a court document that prevents contact with the other parent then, disregard Family #2.
- If both parents still live together, then you only need to fill out Family #1 and disregard Family #2.
- It is your responsibility to notify the parent in Family #2 that they need to contact the school in order to obtain the user name and password for their Skyward access.

**Family #1** Parent/Guardian Name #1: Relationship: Mother Father Stepmother Stepfather Legal Guardian (Paperwork is on file at the school) **(Only circle one)**

| Home Phone #: | Cell #: | Work #: |
|---|---|---|
| | | |

**Family #1** Parent/Guardian Name #2: Relationship: Mother Father Stepmother Stepfather Legal Guardian (Paperwork is on file at the school) **(Only circle one)**

| | Cell #: | Work #: |
|---|---|---|
| | | |

**Family #1** Mailing Address: City, Zip

Siblings who also live at this address w/grade and school attends:

**Family #1** Physical address if different: City, Zip

**Family #2** Parent/Guardian Name: Relationship: Mother Father Stepmother Stepfather Legal Guardian (Paperwork is on file at the school) **(Only circle one)**

| Home Phone #: | Cell #: | Work #: |
|---|---|---|
| | | |

**Family #2** Parent/Guardian Name: Relationship: Mother Father Stepmother Stepfather Legal Guardian (Paperwork is on file at the school) **(Only circle one)**

| Home Phone #: | Cell #: | Work #: |
|---|---|---|
| | | |

**Family #2** Mailing Address: City, Zip

Siblings who also live at this address w/grade and school attends: **(If different from Family #1)**

**Family #2** Physical address if different: City, Zip

**Unless you instruct the school otherwise, only the persons named on this card will be permitted to pick up your child**

List three nearby relatives, friends or neighbors with transportation who will assume temporary care of your child if you cannot be reached.

| Name: | Phone #: | Name: | Phone #: |
|---|---|---|---|
| | | | |

**Please fill out reverse side**

| Name: | Phone #: | Name: | Phone #: |
|---|---|---|---|
| | | | |

Medical Problems: (check all that apply / use line below to specify if necessary)

☐ Allergies (Specify) ☐ Asthma (Specify) ☐ Seizure Disorder (Specify) ☐ Diabetes ☐ Cystic Fibrosis

☐ Other _____ ☐ Vision: Has the doctor prescribed corrective lens for your child? Yes☐ No☐

☐ Hearing: Has the doctor prescribed a hearing device for your child? Yes☐ No☐

Specify _____

Can your child participate in all sports? Yes_____ No _____

☐ Diabetes Management ☐ Inhaler ☐ EpiPen **(Please see school nurse for specific instructions)**

Special Needs: **(School Board policy prohibits any drug, prescription or non-prescription, to be carried onto school campus by a student)**

☐ Prescribed Medication(s): Name of medicine(s)_____

☐ Medical Procedure (ie: tube feeding, suctioning, etc.)

Specify _____

| Doctor Name & Phone #: | Dentist/Ortho Name & Phone #: |
|---|---|
| | |
| Insurance Company & Number: | School Insurance? Medicaid Number:<br>Yes No |
| | |
| Foster Care Agency/Worker Name and Phone # (if applicable) | Hospital Preference: |
| | |

**Military Family Student? (See definition below and then circle appropriate response)** Yes No

Is this a child of **1)** active duty members of the uniformed services, including members of the National Guard and Reserve on active-duty orders pursuant to 10 U.S.C. ss. 1209 and 1211; **2)** members or veterans of the uniformed services who are severely injured and medically discharged or retired for a period of 1 year after medical discharge or retirement; and **3)** members of the uniformed services who die on active duty or as a result of injuries sustained on active duty for a period of 1 year after death

***Exclusions*** Do NOT circle "yes" if the child is of 1) inactive members of the national guard and military reserves; 2) members of the uniformed services now retired, except those in the paragraph above; 3) veterans of the uniformed services, except those in the paragraph above; and 4) other United States Department of Defense personnel and other federal agency civilian and contract employees not defined as active-duty members of the uniformed services.

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

In the event of a 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 or to the nearest hospital emergency room, and 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 to be responsible for my child's care. These persons listed have transportation and are immediately available to come to school.

**I understand that certain educational records of my child will be shared with the district's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such records.**

**Notification/Consent: As parent(s) / guardian(s), I (we) give permission for the School Board of Levy County to release, exchange, review and utilize my child's personally identifiable information to assist in the provision of school health services, and for this information to be disclosed to the Agency for health Care Administration to facilitate verification of Medicaid eligibility; and/or, as applicable, to seek reimbursement from Medicaid for services provided at school. All information will be kept confidential. I understand my child will continue to receive services per his/her Individual Educational Plan whether or not I give consent. I am aware my consent can be withdrawn at any time, and my state/private benefits are not affected. This will be at no cost to me for any reason.**

Signature:_____ Date:_____

(Parent, Guardian, or Agency)

## Please fill out reverse side