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: _____