THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA
EMERGENCY CONTACT INFORMATION

Form# 136
Rev. 5/3/22

Student_____Birthdate_____ ◯Male ◯Female Grade: _____
Last name First Middle

Extended Day ◯Yes ◯No Bus/Route Number:_____Subdivision:_____Teacher:_____

Mailing Address:_____City:_____Zip:_____

Street Address (if different from above):_____

Parent/Guardian 1's Name_____ Phone1_____Phone2_____

E-mail:_____

Parent/Guardian 2's Name_____ Phone1_____Phone2_____

E-mail:_____

Student's Best phone#_____ E-mail:_____

Automated Outbound Notification System

This system will notify you of school and district news using the primary contact number that you designate below and the email above.

Outbound calls 1st contact #_____ Outbound calls 2nd contact #:_____

Automated Emergency Notification System- This notifies you in an emergency by calling/texting both of the numbers that you list below.

Emergency calls 1st contact #_____ Emergency calls 2nd contact #:_____

Emergency Contact Information. If the parent/guardian is not available the person(s) listed below, after identification is verified, are the only person(s) student will be released to

Name_____Phone1_____Phone2_____Relationship_____
Name_____Phone1_____Phone2_____Relationship_____
Name_____Phone1_____Phone2_____Relationship_____

SBM051722

Student Medical Information and Parent/Guardian Consent for Screenings and Emergency Medical Treatment

Physician(s) Name_____ Office phone # _____
Does your child have a Chronic Health condition (physical or mental) or food allergy? □Yes □No Medicaid eligible? ◯Yes ◯No
If yes, what is the physician's diagnosis? _____ Allergic reactions: No □ Yes (describe): _____
If child has a food allergy and needs a food substitute, please contact food service for procedures.
What medication is your child prescribed? _____
What medications will be dispensed at school? _____
ALL MEDICATIONS TAKEN AT SCHOOL ARE REQUIRED TO HAVE A COMPLETED FORM #135 IN THE SCHOOL CLINIC.

Check all of the categories below that apply to your child:

Vision Aid: □ Glasses □Contacts	Does your child have a hearing loss: □Yes □No
Physical Handicap (describe):_	If there is a loss is it:
	□ Unilateral(0ne ear) on the □Right □Left
	□ Bilateral (both ears) Does your child wear a hearing aid(s) □Right □Left □Both

I give my consent for my child to take part in the School Health Services Program that may include:
(NOTE: The absence of circling or checking does NOT imply permission)

Vision Screening □Yes □No	Dental Screening, Specific Observations □Yes □No	Educational Screening, Observations □Yes □No
Speech/Hearing Screening □Yes □No	**Oral** Temperature □Yes □No	Mental Health Screening, Specific □Yes □No
Scoliosis Screening □Yes □No	Body Mass Index □Yes □No	Nutrition Screening/Diet History □Yes □No

In case of accident or serious illness, I ask that the school contact me. If the school cannot reach me, the school is to contact and follow the instructions of the physician(s) listed. If the school cannot contact this physician, the school may do whatever is needed to provide care and treatment for my child. If any person listed on this consent form cannot be reached, school personnel have permission to transport the child to the nearest emergency room. I consent to emergency care provided in the school. In case of an accident or illness when immediate treatment of my child is not needed but where he/she cannot remain at school, I ask that the school contact me to arrange transportation for my child. If the school is unable to contact either me or my spouse, please contact one of the persons listed on the other side to care for my child until I can be reached. The information provided on this form is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____