2025-2026 Nassau County Student Emergency Medical Information

Teacher: _____

(Teacher is for Elementary Schools Only)

In the case of an emergency, it is imperative that the school be able to reach the student's parent (as defined below).
Fill in the information on both sides of this form carefully and accurately. Please use ink and print clearly.

Student Information

Last Name:	First Name:	Middle Name (or initial):
Date of Birth: / /	Grade Level:	Gender: ☐ Male ☐ Female
Student's Physical Address:	City, State, Zip:	
Mailing Address (If different from above):	City, State, Zip:	
Primary Phone:	Student Cell Phone:	
Student Email:		

Who has custody: (Current legal documentation must be on file in the student's cumulative record.)

☐ Both Parents ☐ Mother ☐ Father ☐ Grandparent ☐ Aunt/Uncle ☐ Legal Guardian ☐ Other:_____

Student lives with:

☐ Both Parents ☐ Mother ☐ Father ☐ Grandparent ☐ Aunt/Uncle ☐ Legal Guardian ☐ Parent & Step-Parent ☐ Other:_____

Mother/ Guardian

Last Name:	First:	
Home Address (if different from student):	City, State, Zip:	
Employer:	Work Phone:	Email:

The school mass notification system is used to communicate news, attendance, emergencies, etc. If you want to receive these messages on your cell or home number, please select the appropriate Callout box. Otherwise, the messages will be sent to the Primary Phone number listed under Student Information.

Cell Phone: ☐ Callout - Check to receive school mass notifications	Home Phone: ☐ Callout - Check to receive school mass notifications

Father / Guardian

Last Name:	First:	
Home Address (if different from student):	City, State, Zip:	
Employer:	Work Phone:	Email:

The school mass notification system is used to communicate news, attendance, emergencies, etc. If you want to receive these messages on your cell or home number, please select the appropriate Callout box. Otherwise, the messages will be sent to the Primary Phone number listed under Student Information.

Cell Phone: ☐ Callout - Check to receive school mass notifications	Home Phone: ☐ Callout - Check to receive school mass notifications

Emergency Contacts

List the names of persons to whom we may release your child or whom we may contact if we cannot reach you.

Name	Address	Relationship	Phone Number

Transportation

Regular Arrival Procedures. On a typical day, how will your child **arrive** to school?

☐ Car Dropoff ☐ Walker ☐ Ride School Bus ☐ Drive (High School Students)

☐ Attend OFF-site before-care program (Program:_____)

Regular Dismissal Procedures. On a typical day, how will your child **leave** school?

☐ Car Pickup ☐ Walker ☐ Ride School Bus ☐ Drive (High School Students)

☐ Attend OFF-site after-care program (Program:_____) ☐ Attend ON-site after school program (Program:_____)

PLEASE TURN OVER TO COMPLETE THE BACK

NASSAU COUNTY STUDENT EMERGENCY MEDICAL INFORMATION

Student Last Name: First: Middle:

Physician/ Hospital

In case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

Physician:	Phone:
Hospital:	Phone:

Medical Information

Please check or list any DOCUMENTED medical/mental health diagnoses which may affect the child's progress in school, sports, etc. (Check all that apply):

☐ Asthma. If checked, does the student use an inhaler?	☐ Yes ☐ No ☐ On daily medication
☐ Seizures. If checked, is the student on medication?	☐ Yes ☐ No
☐ Diabetes. If checked, is the student insulin dependent?	☐ Yes ☐ No

☐ Movement limitations (Describe):

☐ Recent illness/hospitalization/surgery (Describe):

☐ Other DOCUMENTED medical/mental health diagnoses (Describe):

☐ Severe Allergies. If checked, please check the type below:

☐ Food/environmental: Specify:_____ ☐ Insect stings/bites: Specify:_____ ☐ Medicines/drugs: Specify: _____

Allergies require:
☐ EpiPen ☐ Benadryl
☐ Other:_____

Does your child wear glasses/contacts? ☐ Yes ☐ No Does your child wear hearing aid(s)? ☐ Yes ☐ No

Sibling(s)

Please list any sibling(s) who currently attend a Nassau County Public School.

First and Last Name	School	Grade Level

Parents will be notified of any problems detected and no treatment, including shots, skin tests or blood tests, will be given without additional parental permission. The Public Health Nurse will assist parents/guardians in obtaining medical help for their child(ren). Health problems will be treated in a confidential manner. You must notify the school principal in writing if you do NOT want your child to participate in one or more of the activities listed.

The Nassau County Health Department, in cooperation with the School Board, will be conducting School Health Screenings during this year. Nursing assessments are a part of the scheduled screenings. A student may be referred by a parent or a member of the school staff at any time for the screenings listed below.

I understand that my child will receive emergency care in the school and health services at school that may include: * First aid for minor injuries, accidents or illnesses * Immunization status and health history reviews * Vision, hearing, height-weight, dental and scoliosis screenings * Assistance with medical/mental health crisis response * Assistance with administration of doctor ordered medications * Health education on specific health topics and approaches to wellness * Assistance with doctor ordered minor, complex or chronic health conditions or procedures

I authorize the School District of Nassau County, Florida to release and exchange my child's confidential information to agencies of the State of Florida to determine Medicaid eligibility and, if applicable, to bill Medicaid for reimbursable Certified School Match services referenced on my child's individual education plan (IEP), or other applicable plan, and receive Medicaid reimbursement for Exceptional Student Education (ESE) or other necessary services provided to my child while at school. I understand that my child will receive services referenced on his/her plan(s).

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 physical or mental health services to students. I also understand and agree that my child's treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records.

I understand that in case of an accident or serious injury, I will be contacted. If I cannot be reached, I understand the contact person(s) listed on this form as the emergency contact(s) may be contacted.

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

Has your family temporarily lost housing? ☐ Yes ☐ No

Your family may qualify for additional resources through the FIT program if you are living in one of these situations because of loss of housing: sharing housing, camper, motel, car, substandard, etc. Call 277-9021 for more information.

These situations, in and of themselves, do not count as abuse and are not reported to any agency.

I declare that the information on this card is true and correct. I will notify the school office immediately of any changes.

Signature:_____ Date:_____

Relationship to Student:_____

Revised 4-10-2023