SARASOTA
CHRISTIAN SCHOOL

Health Emergency Parental Consent Form

The Sarasota County Health Services Plan makes provision for health record, nursing consultation, emergency care treatment and non-invasive screening (i.e., hearing, vision, scoliosis, height & weight measurement). Any parent wishing to opt their child out of a screening must do so in writing. Temperature screening will be done if deemed necessary. A limited number of topical medications, as have been approved by school district policy and listed in the School Health Services Manual, may be used in the health room. Parent/guardian has the responsibility of listing any allergies on this form.

In case of serious illness or injury where immediate care is needed, the school or its representative has my permission to contact the appropriate emergency medical service. The emergency medical service has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for emergency treatment cost.

In the case of an accident or illness where immediate treatment of my child is not indicated, but where (s)he is unable to remain at school, I request that the school contact me or my designee to arrange care and/or transportation for my child. In the event no designated person is available, emergency medical services may be contacted for further assessment and possible transport and treatment. I understand that I must notify the school if there are any changes in this health emergency information.

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 treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such records.

Parent/Guardian Signature: _____ **Date:** _____

Student Name: _____ **DOB:** _____ **Sex:** _____

Address: _____
Street City State Zip

Allergies (specify): _____

Other Health Concerns /Special Instructions/Required Medications, etc.: _____

_____

Student's Physician: _____ Phone: _____

Student's Dentist: _____ Phone: _____

Parent/Guardian Name: _____ **Relation:** _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Name: _____ **Relation:** _____

Home Phone: _____ Cell Phone: _____

❑ Custody Alert: _____