THE SCHOOL BOARD OF HERNANDO COUNTY
STUDENT REGISTRATION & EMERGENCY CONTACT INFO

FOR OFFICE USE ONLY:
TEACHER_____
ENTRY DATE_____
STUDENT ID#_____

Current Date 05/10/22 Grade _____ School _____

Student Legal Name - LAST _____ FIRST _____ MIDDLE _____

Date of Birth MM/DD/YYYY _____ Gender _____

Birth City _____ Birth State _____ Birth Country _____

Active Military Family Student _____ Student Social Security Number (Optional) _____

☐ Hispanic/Latino Ethnicity? Federal Race _____

Permission for non-school personnel to interview or photograph student:

☐ Yearbook ☐ School Photo ☐ Public Media/Website/Video ☐ Interview

Prior School _____ Prior School State _____ Prior School Country _____

Are you enrolling in our district due to a natural disaster? _____

Has your child ever been retained? _____ If YES, which grade(s) _____

Has your child ever been enrolled in Special Ed or remedial education program? _____

Has your child ever been referred or received mental health services? _____

Has your child ever been enrolled in Hernando County Schools? _____ If YES, Name of last school _____

Student Transportation _____ I or my spouse are currently employed with _____

Please list all school age siblings residing in the home who are enrolled in Hernando County Schools:

Sibling Name _____ School _____ Grade _____

Sibling Name _____ School _____ Grade _____

Sibling Name _____ School _____ Grade _____

Sibling Name _____ School _____ Grade _____

Medicaid Notification and Consent: If my child is covered by Medicaid and receives services in school, information may be used by the District to bill Medicaid for the following: transportation, behavioral and mental health services (including crisis intervention and counseling), and health services such as occupational, physical, speech-language therapy, nursing, and augmentative services, as established on the IEP or Plan of Care. IEP/Plan of Care services are provided at no cost, regardless of consent. You may withdraw parental consent at any time by providing written notice to the school district. Any billing authorization of records disclosed are available upon request. Please choose one of the following and sign in the indicated area.

☐ **YES**, my child is covered by Medicaid and receives services under an IEP or Plan of Care. I consent for the District to bill Medicaid for those services provided. I understand that my consent is a **one-time** requirement and will remain in effect for the period of time my child is enrolled in Exceptional Education programs.

☐ **NO**, I do not give my consent.

Parent/Guardian Name _____ Signature _____

Relation to Student _____ Current Date 05/10/22

White: Clinic Pink: Cumulative file Yellow: Office

RESIDENCE & EMERGENCY CONTACT INFORMATION

Student Name _____

Residence Address _____ City _____ Zip _____

Phone _____ Mailing Address if different from above _____

Parent/Guardian 1 Name _____ Relation to student _____

Phone - Work _____ Phone - Cell _____

Email _____

Parent/Guardian 2 Name _____ Relation to student _____

Phone - Work _____ Phone - Cell _____

Email _____

Student lives with: _____

If student does not live with parent, name/relationship of guardian _____

The enrolling parent/guardian **must provide** a certified court order indicating sole custody, or a restraining order, if they do not wish the other parent/guardian to have access to their child.

For School Office Use Only: Order on file? _____ Staff member verifying receipt of Order _____

Emergency Contacts: It is **mandatory** that the emergency numbers/contacts be provided. To serve your child in case of accident or sudden illness, it is necessary that you list those individuals **other than** the parent(s)/guardian(s) who are authorized to pick up your child through the clinic/office. (Example: Stepparent, Neighbor, Other Relative, etc.)

1. Name _____ Relation to student _____ Phone _____
2. Name _____ Relation to student _____ Phone _____
3. Name _____ Relation to student _____ Phone _____
4. Name _____ Relation to student _____ Phone _____
5. Name _____ Relation to student _____ Phone _____
6. Name _____ Relation to student _____ Phone _____

White: Clinic Pink: Cumulative file Yellow: Office

HEALTH INFORMATION

Student Name _____

MEDICAL INFORMATION: YOU MUST CONTACT THE SCHOOL HEALTH PROFESSIONAL IF YOUR STUDENT HAS A HEALTH CONDITION OR REQUIRES CARE AT SCHOOL. DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS? CHECK ALL THAT APPLY.

- ☐ Asthma - medication needed at school
- ☐ Asthma - no medication needed at school
- ☐ Allergy - Epi-pen required
- ☐ Allergy - no Epi-pen required
- ☐ Attention Deficit Disorder
- ☐ Heart Condition
- ☐ Cystic Fibrosis
- ☐ Cerebral Palsy
- ☐ Hemophilia
- ☐ Cancer
- ☐ Seizures/Epilepsy
- ☐ Wears Contacts/Glasses
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Sickle Cell Disease

Other _____

Does your child require regular or emergency medication at school? _____

If YES, a completed and signed Medication Authorization form must be submitted to the school.

Doctor's Name _____ Phone _____

Dentist's Name _____ Phone _____

Notification of Health Services to be provided: The District School Board of Hernando County provides health services to students in partnership with the Florida Department of Health, Hernando County. The partner is required by law to maintain the privacy of your child's protected health information. Immunization information required for school attendance may be shared between Hernando Public Schools and the Florida Department of Health, Hernando County.

Screenings will be provided as listed below. Students that are new to the state and students referred by teachers will also receive vision and/or hearing screening by DOH-Hernando or the school health professional. If vision screening shows a need for a follow-up vision examination, and if your child is eligible, or otherwise financially qualified, FVQ or Heiken may provide this examination at no charge, with your consent. The results of these vision screenings and vision examinations will be shared with designated Hernando County Public School employees and DOH - Hernando. Parents will be informed of screening results.

The following Health Screenings to be performed:

Screening	Grades	Schools
Vision (DOH-Hernando)	K, 1, 3, 6	Brooksville, Chocachatti, Deltona, Eastside, Floyd, Moton, Pinegrove, Spring Hill, Suncoast, Westside, Challenger, Explorer, Winding Waters, Fox Chapel, Parrott, Powell, West Hernando
Hearing (DOH-Hernando)	K, 1, 6	All elementary, middle and K-8 schools (see above)
Height/Weight (DOH-Hernando)	1, 3, 6	All elementary, middle and K-8 schools (see above)
Scoliosis (DOH-Hernando)	6	All K-8 and middle schools (see above)
Hearing & Vision (DOH-Hernando)	K-5	Any newly Florida enrolled student in all elementary and K-8 schools (see above)

Parent Authorization: I/We the undersigned, do hereby authorize officials of the Hernando County School District to contact directly the persons named on this form. In the event parents, physicians, or other persons named on this form cannot be reached, if and to the extent required by law, I/we authorize school officials to transport and to facilitate, through a physician of their choice, any emergency medical care that may be deemed necessary in their judgement for the health and well-being of the above student in the course of school activities or such travel. The DOH-Hernando in conjunction with the Department of Education provides school health nursing services for Hernando County Schools. I/We understand that all health related information I provide to the school regarding my child will be shared between the two agencies as needed in the performance of their duties. The Hernando County Public Health nurses may also provide treatment to your child when assisting in the clinic. I/We also agree that the expense for such transportation and/or emergency care shall not be borne by the School District or its employees.

Parent/Guardian Name _____ Signature _____

Relation to Student _____ Current Date 05/10/22