

STUDENT NAME: _____ DATE OF BIRTH: _____

SCHOOL YEAR: _____ GRADE: _____

HOME ADDRESS: _____
Street City ZIP

STUDENT RESIDES with: _____

PRIMARY EMAIL ADDRESS(ES): _____

Please place name, relation and phone number below in order for PBS Faculty/Staff to call for ANY reason:
Parent/Legal Guardian MUST be listed below.

1. _____ RELATION _____ PHONE _____

2. _____ RELATION _____ PHONE _____

3. _____ RELATION _____ PHONE _____

4. _____ RELATION _____ PHONE _____

5. _____ RELATION _____ PHONE _____

BE SURE TO COMPLETE BOTH SIDES OF THIS CARD

STUDENT'S FULL NAME: _____

KNOWN ALLERGIES: _____

I understand that unless I request an exemption in writing to the Head of School my child, _____, will participate in the School Health Service Program, which may include health appraisal and screenings in vision, hearing, growth and development, nutrition, dental, health, scoliosis and communicable diseases as required by Florida Law.

I give permission for Pace Brantley School to administer prescription medicine with forms completed by a physician.

In the event of a serious accident or illness, I request the school contact me. If I cannot be reached, I hereby give consent to members of the Pace Brantley School staff to make whatever arrangements are necessary to provide emergency care and treatment for my child. I will assume responsibility of payment for services rendered.

In case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain at school, I request that the school contact me, my spouse or anyone listed on the reverse side of this card to arrange transportation for my child.

SIGNATURE OF LEGAL GUARDIAN: _____ DATE: _____

PRINT NAME: _____

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