EMERGENCY INFORMATION CARD SCHOOL YEAR: __________ HEALTH OFFICE

Student's Name (Please Print): ____________________ Grade:____ Teacher: __________
Last First

Address:________________________________ Email: ________________
Street Town Zip

Home Phone:________________ Cell Phone (Mother): ________________ Cell Phone (Father):________________

Father's Name: ________________ Work Phone: ________________ Work Place: ________________

Mother's Name: ________________ Work Phone: ________________ Work Place: ________________

☐ Please check this box if there has been a name change of parent/guardian, address or telephone number.

Please list the names of two neighbors or NEARBY relatives who may be contacted and will assume temporary care of your child if you cannot be reached.

1. Name: ________________ Address: ____________________ Phone: ____________ Cell #: ____________

2. Name: ________________ Address: ____________________ Phone: ____________ Cell #: ____________

If your child is involved in a medical EMERGENCY the school authorities will arrange for transportation of the child to the nearest hospital. Parents are responsible for the financial obligation for such emergency care and transportation from the hospital. In the event that none of the persons can be contacted; I hereby give my permission for my child (name) ____________________ to be transported the nearest medical facility for treatment.

Signature of Parent or Guardian ________________________________ Date ____________

Family physician's name: ________________________ Phone: ____________________

Student's Date of Birth:____________ Student ID# ____________________ (Office Use Only)

(over please)
(Revised 7/2009)

List any medical/surgical care your child has received during the past year.________________________________

____

Dental Exam __________ (date) __________ (braces) Eye Exam __________ (date) __________ (contacts glasses)

Allergy __________ (kind) __________ (medications) Allergy Reactions __________ (date) __________ (medications)

Immunizations/Tetanus __________ (date) __________ (type) __________ (date) __________ (type)

Restrictions________________________________
type

Known conditions which may cause an emergency: ________________________________

Additional health information about your child: ________________________________

____

Please list <u>all</u> medications your child takes at home and in school: ________________________________

____

I give my consent for my child ________________________ to take part in the following health services:

YES	NO	
☐	☐	Receive medical treatment in the case of an emergency
☐	☐	Health information to be shared with appropriate school personnel if it will protect my child's health and safety
☐	☐	Scoliosis screening (grades 5 through 12)
☐	☐	The school nurse may contact my child's physician regarding health information and medications listed above.

Does child have Health insurance? ___YES or ___ NO - If yes, name of insurance company____________________
NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature:____________________ Printed Name:____________________ Date:____________

Written consent required pursuant to 20 U.S.C§ 1232(b)(1) and 34C.F.R. 99.30 (b)