Emergency/Health Information

Please print Grade___________________

Student's Name____ Bus No.__________________

Last First Birthdate________________

Mailing Address ____________________________ Zip__________ Home Tel.________________

____

Parent____ Cell_________________________

First Name Address if different Work______________________

Parent____ Cell_________________________

First Name Address if different Work________________________

List 2 neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

1. Name____
   Address_____________________________________Tel.________________________
2. Name____
   Address_____________________________________Tel.________________________

Does student have health insurance?

Yes___ Name of insurance company____

No ___ NJ Family Care 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 on line.

Yes___ You may release my name and address to the NJ Family Care Program

No ___ to contact me about health insurance.

Parent Signature____________________Printed Name____________________Date________

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

PLEASE COMPLETE THE OTHER SIDE

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me and if circumstances warrant, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary, including transport to a hospital.

Medical conditions:____

Allergies:____

Current medications:____

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

____

Dental exam____

Date Braces

Eye exam____

Date Contacts Glasses

Please circle one:

I (give) (do not give) permission for this information to be released to school personnel as deemed necessary by the school nurse.

SignatureParent/Guardian___________________________________Date________________

Local Physician's Name____

Address____

Office Telephone No. _____________________________________FaxNo.___________________________________

Dentist's Name____Tel.No_________________________