

# NAME OF SCHOOL DISTRICT

\_\_\_\_\_

ID# \_\_\_\_\_  
Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth (Mo/Day/Year) \_\_\_\_\_  
Address \_\_\_\_\_ School \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ Grade \_\_\_\_\_  
Home Telephone (\_\_\_\_) \_\_\_\_\_ Teacher/H.R. \_\_\_\_\_

**To Parent or Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for emergency calls:**

Name	Address	Telephone
Mother/ _____ <small>Guardian</small>	Home _____ Work _____	_____
Father _____	Home _____ Work _____	_____

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

Name _____	Name _____
Home/ _____ <small>Address</small>	Home/ _____ <small>Address</small>
Work/ _____	Work/ _____
Telephone: Home _____ Work _____	Telephone: Home _____ Work _____
Relationship _____	Relationship _____

Please list other children attending New Jersey Public Schools (Name, School)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

**Yes** \_\_\_\_\_ If Yes, name of insurance company \_\_\_\_\_

**No** \_\_\_\_\_ 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](http://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. § 1232g (b)(1) and 34 C.F.R. 99.30 (b).*

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 \_\_\_\_\_

Allergic Reaction

\_\_\_\_\_ date \_\_\_\_\_

\_\_\_\_\_ medications \_\_\_\_\_

Immunizations/Tetanus

\_\_\_\_\_ date \_\_\_\_\_

\_\_\_\_\_ type \_\_\_\_\_

Restrictions

\_\_\_\_\_ type \_\_\_\_\_

Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Dentist \_\_\_\_\_ Telephone \_\_\_\_\_

Hospital \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent(s) / Guardian(s)

Date