**Health Office - Emergency Contact Form**

**Section 1 – Student Information**

|  |  |  |
| --- | --- | --- |
| ID# | DOB |  |
| Last Name | First Name MI |  |
| Address |  |  |
| City |  Zip | Grade |
| Telephone: | Home School | Current Teacher/HR |

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:

|  |  |
| --- | --- |
| MOTHER/GUARDIAN’S FULL NAME | HOME TEL |
| Home Address (if different) | WORK TEL |
|  | CELL |
|  | EMAIL |

|  |  |
| --- | --- |
| FATHER/GUARDIAN’S FULL NAME | HOME TEL |
| Home Address (if different) | WORK TEL |
|  | CELL |
|  | EMAIL |

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

|  |  |
| --- | --- |
| FULL NAME | HOME TEL |
| Address | WORK TEL |
|  | CELL |
| RELATIONSHIP | EMAIL |
|  |  |
| FULL NAME | HOME TEL |
| Address | WORK TEL |
|  | CELL |
| RELATIONSHIP | EMAIL |

Please list any other children in the home attending New Jersey Public Schools:

 Name School

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

Does this child have any health Insurance, including NJ Family Care/Medicaid, Medicare, private or other?

\_\_\_\_ Yes If yes, name of insurance company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ No NJ Family Care provides free or low cost for uninsured children and certain low-income parents.

For more information call 800-701-0710 or visit www.nlfamilycare.org to apply online.

\_\_\_\_ You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

*Written consent required pursuant to 20 LI.S.C.S1232g(b%l) and 34 C.F.R.99.30 (b).*

List and describe any medical/surgical care your child has received in the past year:

|  |  |
| --- | --- |
| Dental Exam: |  |
| Eye Exam: | Contacts? |
| Allergy: | Medications? |
| Allergic Reaction: | Medications? |
| Immunizations / Tetanus: | Type? |
| Restrictions: |  |

|  |  |
| --- | --- |
| Doctor Name | Doctor Phone |
| Dentist Name | Dentist Phone |
| Hospital Name City  | Hospital Phone |

I, the undersigned, do hereby authorize officials of The Newgrange School and The Laurel School 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 judgment for the health of the aforesaid child.

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

Date: \_\_\_\_\_\_\_\_\_\_\_ Signature of Parent / Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE NOTIFY THE SCHOOL IMMEDIATELY OF CHANGES OR MODIFICATIONS TO ANY/ALL INFORMATION STATED.**