

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

SECTION 2 – Medication Information

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.njfamilycare.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 L.I.S.C.S1232g(b%) 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	Hospital Phone
City	

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.

