

**WEST MILFORD TOWNSHIP PUBLIC SCHOOLS**

**Emergency Information Form**

**Dear Parent or Guardian:** To serve your child in case of sudden illness, it is necessary to provide the following information for emergency purposes. Please correct any outdated information and complete all missing information. Write "N/A" if the area is not applicable or information is not available. Sign and return to the main office. This form will eliminate the need to complete multiple emergency cards.

ID# \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ School: \_\_\_\_\_

City: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Teacher/H.R.: \_\_\_\_\_

Name	Address	Telephone	Cell
Mother: _____	Home: _____ Workplace: _____	_____	_____
Father: _____	Home: _____ Workplace: _____	_____	_____

E-mail Address: \_\_\_\_\_

List two neighbors or nearby relatives who will assume temporary care of your child.

Name	Name
_____	_____
Home Address	Home Address
Work Address	Work Address
Telephone Home	Telephone Home
Telephone Work	Telephone Work
Cell Number	Cell Number
Relationship	Relationship

Does child have Health Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Has Health Insurance Changed? Yes \_\_\_\_\_ No \_\_\_\_\_

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 <a href="http://www.njfamilycare.org">www.njfamilycare.org</a> to apply online. You may release my name address to the NJ FamilyCare Program to contact me about health insurance.
Signature _____	Printed Name: _____ Date: _____

Written consent required to release your name 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.

Does your child attend daycare? Yes _____ No _____ if Yes, Where _____	Braces:	Y	N
List Medical Conditions:	Glasses:		
Medications (taken @ home and school):	Hearing Aides:		

List Allergic / Reactions: \_\_\_\_\_

List Medical Restrictions: \_\_\_\_\_

I agree to have my child screened for scoliosis? For Grades 5-12 (Please initial)

	Name	Telephone	Sibling Name	School Attending
Doctor:	_____	_____	_____	_____
Hospital:	_____	_____	_____	_____

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 judgment, 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: \_\_\_\_\_ Date: \_\_\_\_\_