STUDENT EMERGENCY CARD

(Complete both sides. Please notify the school of any changes during the school year.) Date: __________

GAVLAK _____ JEFF. _____ JR./SR.H.S. ______ GRADE ________ TEACHER ______________________________

Pupil's Last Name First Name Middle Initial Date of Birth Age

Home Address Home Phone No. ( ) Indicate an Unlisted number with an *

e-mail: ____

Circle with whom child resides: Both parents Mother Father Guardian (write name & relationship) ______________

*Circle who has legal custody: Both parents Mother Father Guardian (write name & relationship) ______________

Please indicate if there are any restrictions pertaining to who is permitted to pick up your child.

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*Contact the principal if special circumstances exist concerning the custody of your child. Be prepared to present a copy of the custody papers and/or restrictions of contact with your child by another person.

Mother's Name ______________________ Work # ( ) ______________ Cell# ( ) ______________

Father's Name ______________________ Work # ( ) ______________ Cell# ( ) ______________

Persons to whom school may entrust child in case parent cannot be reached.

1. ______________ ______________ ( ) ______________ ______________
Name Address Phone # Relationship

2. ______________ ______________ ( ) ______________ ______________
Name Address Phone # Relationship

Signature of parent/legal guardian: ______________________ Date: ______________

THE CONTENTS OF THIS EMERGENCY CARD DO NOT CONSTITUTE ANY ADMISSION OF LIABILITY ON THE PART OF THE SCHOOL SYSTEM OR ANY EMPLOYEE THEREOF.

Sibling Information (Brothers and Sisters)

	Name	Age	School Presently Attending	Phone # of School
1.				( )
2.				( )
3.				( )
4.				( )

Health Information:

Child's Physician: ______________________ Phone #: ( ) ______________ Hospital Choice: ______________

DID YOU PURCHASE SCHOOL INSURANCE? YES _____ NO _____

DOES YOUR CHILD HAVE HEALTH INSURANCE? Yes ___, No___ If Yes, name of insurance company______________________

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 to apply online. **You may release my name & address to the NJ Family Care Program to contact me about health insurance**. ______________ ______________ ______________
Signature Printed Name Date

Is there any on-going illness, disease, or physical condition of which the Nurse should be aware? Yes ___ No ___ If Yes, explain below:

____

____

Does your child take medication? YES ___ NO ___ Specify type & reason. Obtain required forms from nurse to be filled out by physician

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Does your child have any allergies: YES ___ NO ___ If so, please describe ______________________________

I agree that the school nurse may discuss my child's condition, diagnosis, clarify and/or define a procedure, medication, or degree of participation in physical activities including gym with the appropriate school personnel and authorizing physician.

In emergency situations, and/or if I/we cannot be reached, school district personnel (e.g. nurse, principal, teacher, coach, athletic trainer, etc.) may act on our behalf to obtain emergency treatment. The attending physician/hospital may render emergency medical services to my child.

______________________ ______________________ Date: ______________
(Print) Parent/Guardian Signature of Parent/Guardian