

**CALIFON PUBLIC SCHOOL  
STUDENT EMERGENCY INFORMATION 2011/2012**

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Home Phone #:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**EMERGENCY CONTACTS: Where can parents be reached during school hours in an emergency?**

**Mother's Name:** \_\_\_\_\_ **Work #** \_\_\_\_\_ **Cell #** \_\_\_\_\_  
**Father's Name:** \_\_\_\_\_ **Work #** \_\_\_\_\_ **Cell #** \_\_\_\_\_

**DESIGNATED CONTACTS: List two nearby friends/relatives who will assume temporary care of your child should they become ill or injured at school if you cannot be reached. (Be sure to give names of people who can be at school in less than 30 minutes)**

<b>Name:</b> _____	<b>Name:</b> _____
<b>Relationship:</b> _____	<b>Relationship:</b> _____
<b>Home:</b> _____	<b>Home:</b> _____
<b>Work:</b> _____	<b>Work:</b> _____
<b>Cell:</b> _____	<b>Cell:</b> _____

**SUPERVISION AT DISMISSAL:**

**Califon students have permission to walk home after dismissal unless otherwise designated. Parents/Guardians of students who request supervision at dismissal must designate permitted escorts on this form.**

\_\_\_ **YES, my child needs to be escorted after dismissal.**

<b>Designated Person:</b> _____	<b>Tel. #:</b> _____
<b>Designated Person:</b> _____	<b>Tel. #:</b> _____

\*You may list additional names separately if needed.

\_\_\_ **NO, my child does not need supervision at dismissal.** He/she may walk home at dismissal regardless of early dismissal, inclement weather conditions, and emergency closings.

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

**PUBLICITY/ CONSENT:**

**In certain instances or special events at Califon School such as contests, awards, assemblies etc. there may be opportunity for children to be photographed or identified. Please indicate preference below.**

**I grant permission for Califon School to do the following (initial all that apply):**

- \_\_\_\_\_ Publish my child's photograph (*without* identifiers) on the school or classroom website
- \_\_\_\_\_ Publish my child's name (first name, last initial) on school websites
- \_\_\_\_\_ Send my child's photograph and name for publication to newspapers and local TV networks
- \_\_\_\_\_ Display my child's full name in "good news" announcements via email or outdoor bulletin board
- \_\_\_\_\_ I do not want any form of publicity involving my child (**no other line should be initialed**)

Please complete both sides. Return to Main Office.  
Ms. Fogg

**NJ DOE INFO:**

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

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**As per NJAC 6A:32-7.19(g)**

**Does your child have Health Insurance?**

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

**No** \_\_\_\_ NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call 1-800-701-0710 or visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply on line. 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 10 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: \_\_\_\_\_

Eye Exam: \_\_\_\_\_

Allergy: \_\_\_\_\_

Allergic Reaction : \_\_\_\_\_

Asthma (triggers): \_\_\_\_\_

Other Medications: \_\_\_\_\_

Recent Immunizations: \_\_\_\_\_

Restrictions: \_\_\_\_\_

\_\_\_\_\_

Braces: \_\_\_\_\_

Contacts: \_\_\_\_\_ Glasses: \_\_\_\_\_

Allergy Medications: \_\_\_\_\_

Last Episode: \_\_\_\_\_

Last Episode: \_\_\_\_\_

Last Tetanus: \_\_\_\_\_

**Doctor** \_\_\_\_\_

**Dentist** \_\_\_\_\_

**Hospital** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this form 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 form, 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 of Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_