

CALIFON PUBLIC SCHOOL
STUDENT EMERGENCY INFORMATION

Student Name: _____ Date of Birth: _____
Address: _____ Grade: _____
Home Phone #: _____

Where can parents be reached in an emergency? (Place of business, etc.)

Mother: Work # _____ Cell # _____
Father: Work # _____ Cell # _____

List two neighbors or nearby 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):

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Home: _____ Home: _____
Work: _____ Work: _____
Cell: _____ Cell: _____

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

Does child have Health Insurance?

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 1-800-701-0710 or visit www.njfamilycare.org to apply on line.
You may release my name and address to the NJ FamilyCare 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: _____ Braces: _____
Eye Exam: _____ Contacts: _____ Glasses: _____
Allergy: _____ Allergy Medications: _____
Allergic Reaction : _____ Last Episode: _____
Asthma (triggers): _____ Last Episode: _____
Other Medications: _____
Recent Immunizations: _____ Last Tetanus: _____
Restrictions: _____

Doctor _____ Phone Number: _____
Dentist _____ Phone Number: _____
Hospital _____ 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: _____