Newgrange School
An extraordinary place to learn

Health Office - Emergency Contact Form

SECTION 1 - STUDENT INFORMATION

ID # : ______________ **Date of Birth:** ______________

Last Name: ______________ **First:** ______________ **Intial:** ______________

Address: ______________ **Home School:** ______________

City: ______________ **Zip:** ______________ **Teacher / HR:** ______________

Home Telephone: ______________ **Grade:** ______________

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 emergancy calls:

	NAME	ADDRESS		Telephone
Mother/Guardian:		**Home**		
		Work		
Father:		**Home**		
		Work		

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

Name			**Name**		
Home Address			**Home Address**		
Work Address			**Work Address**		
Telephone: Home		**Work**	**Telephone: Home**		**Work**
Relationship			**Relationship**		

Please list other children attending New Jersey Public Schools:

Name	School

☐ Please Check this box if there has been a name change of parent/guardian, address or telephone number.

SECTION 2 - MEDICATION INFORMATION

Does this child have any health insurance, including NJ FamilyCare/Medicaid, Medicare, private or other?

Yes ________ **If yes, name of insurance company:** ______________

No ________ **NJ FamilyCare 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 FamilyCare Program to contact me about health insurance.

Signature: ______________ **Printed Name:** ______________ **Date:** ______________

Written consent required puruant to 20 U.S.C. S 1232g(b)(1) and 34 C.F.R. 99.30 (b).

List any medical/surgical care your child has received during the last year:

Dental Exam	date	Braces
Eye Exam	date	contacts / glasses
Allergy	kind	medications
Allergic Reaction	date	medications
Immunizations/Tetanus	date	type
Restrictions	Type	

Doctor ______________ **Telephone** ______________

Dentist ______________ **Telephone** ______________

Hospital ______________ **Address** ______________ **Telephone** ______________

I, the undersigned, do nerby authorize officials of New Jersey Public Schools to contact directly the persons names 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 actions is deemed necessary in the judgement, 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.

Parent/guardian Signature: ______________ **Date:** ______________