ROXBURY TOWNSHIP PUBLIC SCHOOLS – EMERGENCY CARD

Grade/HR ____________

Pupil ____ Sex ________ Birth Date _________________
Last First Middle Init.

Address ____ Home Phone ____________________
Street Town Zip Code

Father's Name ______________________________ Employer ____________________ Work Phone _____________
Email ____ Cell Phone _____________

Mother's Name ______________________________ Employer ____________________ Work Phone _____________
Email ____ Cell Phone _____________

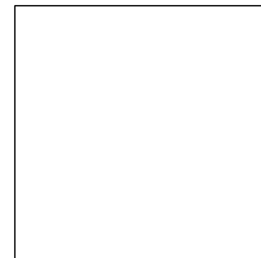
Resides with: ❑ Mother ❑ Father ❑ Both ❑ Guardian (Guardian's Name ______________________________)

Individuals who will assume temporary care of your child if you cannot be reached: **(Must be completed)**

____
Name Address Phone

____
Name Address Phone

List ALL Medication(s) Child is Taking ____
Allergies (medication/food/insect) __________________________________



I give permission to release medical information to the staff necessary to assure the safety of my child.
I, the undersigned, do hereby authorize the N.J. Public Schools to contact directly the persons name 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 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** ______________

Entire Front and Back of Card Must be Completed

Does child have Health Insurance?

Yes _____
No _____

If Yes, name of insurance company _____________________
NJ FamilyCare provides free and 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 and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _________________________ **Date:** ___________
Printed Name: _______________________________________
Written consent required pursuant to 20 U.S.C. 132g (b) (1) And 34 C.F.R. 99.30 (B)

Siblings: (Name, Age, and School/Grade)

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Medical Information: (medical care your child has received during the past year)

Physician ____ Phone ______________________________
Dentist__ ____ Phone ______________________________
Hospital ____

Dental Exam (date) ________________________ Eye Exam (date) _______________ glassess _____ contacts ______

Medical Problems: ______________________________________
Illnesses: ____ Surgery: _____________________________
Injuries: ____ Hospitalization: _______________________
Immunizations: ____ Other: ______________________________