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)

_____

_____

_____

_____

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: _____
Injuries: _____
Immunizations: _____

Surgery: _____
Hospitalization: _____
Other: _____