PARENT EMERGENCYCONSENT FORM / ILLNESS INFORMATION

PERSONAL DATA

Student's name _____Grade_____Date of Birth_____

Father's Name _____ Mother's Name _____

Home Address _____Phone Number _____

PLACE OF EMPLOYMENT:

Father _____Working Hours _____Business Phone _____

Mother _____ Working Hours _____Business Phone _____

NAME OF LOCAL PERSON TO CONTACT IF PARENT(S) ARE NOT AVAILABLE (THIS MUST BE COMPLETED)

Name _____Address _____Phone_____

Name _____Address _____Phone_____

HEALTH INFORMATION

DOES YOUR CHILD HAVE ANY UNUSUAL HEALTH CONDITIONS? Yes _____ No _____

IF YES, PLEASE INDICATE: (ALSO INDICATE MEDICATIONS USED INCLUDING INHALERS AND EPI-PEN)

___Asthma	**___Bee Sting Allergy**	**___Internal Irregularities**	**___Deafness**	**___Physical Handicap**
___Kidney/Bladder	**___Other Allergy(List)**	**___Convulsive Seizures**	**___Surgical**	**(Describe) _____**
___Arthritis	**_____**	**___Sight Impairment**	**___Fractures**	**_____**
	_____	**___Wears Glasses**	**___Heart**	**Other: _____**
___Diabetes: ___mild ___ severe				**_____**

PLEASE FILL OUT REVERSE SIDE

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

_____NO My child **does not** have health insurance. 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 20 U.S.C.§1232g(b)(1) and 34 C.F.R. 99.30(b)

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more Information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

_____YES My child has health insurance

PHYSICIAN/DENTIST INFORMATION

Family Doctor _____Office Phone _____
Address _____
Family Dentist _____Office Phone _____
Address_____

RELEASE

If emergency treatment is required, and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Parent Signature _____Date _____
Parent Signature _____Date _____

SPECIAL NOTE: Please notify school officials immediately as to changes or modifications to any/all information stated