Please fill back page
1 for each child

ESTELL MANOR SCHOOL
EMERGENCY CARE INFORMATION

School Year: 2019.2020

******IMPORTANT CHANGES TO THIS FORM***PLEASE BE SURE TO FILL OUT THE REVERSE SIDE OF THIS FORM.**
WE ARE REQUIRED TO REQUEST THIS INFORMATION BY THE STATE OF NEW JERSEY

PLEASE BE SURE TO FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE WITH CURRENT INFORMATION

PUPIL'S NAME:_____ GRADE:_____ BIRTHDATE: _____

PUPIL'S NAME: _____ GRADE:_____ BIRTHDATE: _____

PUPIL'S NAME:_____ GRADE:_____ BIRTHDATE: _____

PUPIL'S NAME: _____ GRADE:_____ BIRTHDATE: _____

Please indicate if any of the emergency home/cell phone numbers or your address have been changed from last year **Yes** ☐

PLEASE INDICATE YOUR E-MAIL ADDRESS AS NOTICES MAY BE SENT HOME THRU E-MAILS RATHER THAN PAPER

****Parent(s) Guardian(s) Full Name**:** _____ **E-Mail address:**_____

**** Mother's Cell Phone No.** _____

****Home Address**:** _____ **** Home Telephone No.** _____

****Father's Cell Phone No.** _____

NOTE TO PARENT OR GUARDIAN: TO SERVE YOUR CHILD IN CASE OF ACCIDENT OR SUDDEN ILLNESS, IT IS NECESSARY THAT YOU FURNISH THE FOLLOWING INFORMATION FOR EMERGENCY CALLS:

Father's Employment: _____ Telephone No.: _____

Mother's Employment: _____ Telephone No.: _____

LIST TWO FRIENDS OR NEARBY REALATIVE WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD AND/OR MAY PICK THEM UP FROM SCHOOL IF YOU CANNOT BE REACHED:

1. Name: _____ Telephone No.:_____
   Cell No._____
   Address: _____ Relationship: _____

2. Name: _____ Telephone No.: _____
   Cell No.
   Address: _____ Relationship: _____

SIGNATURE OF PARENT/GUARDIAN: _____

(COMPLETE BOTH SIDES OF THIS FORM)

Does your child have Health Insurance?

Yes____ If yes, name of insurance Company_____

No_____ NJ Family Care provides free or 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 Family Care 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)

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

_____

Dental Exam	_____ Date	_____ Braces	
Eye Exam	_____ Date	_____ Contacts	Glasses
Allergy	_____ Kind	_____ Medications	
Allergic Reaction	_____ Date	_____ Medications	
Immunizations/Tetanus	_____ Date	_____ Type	
Restrictions	_____		

OTHER HEALTH CONDITION: Please list any conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems, or any chronic condition, etc.

Name of Child: _____ Health Condition:_____

_____

_____

Doctor_____ Telephone_____
Dentist_____ Telephone_____
Hospital_____ Address_____ Telephone_____

I the undersigned do hereby authorize officials of New Jersey Public Schools to contact directly the persons named 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 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(s)/Guardians **Date**