If you have more than 3 Students ask for a 2nd form

ESTELL MANOR SCHOOL
EMERGENCY CARE INFORMATION

School Year: 2021/2022

PLEASE BE SURE TO FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE a copy of this form is available for our staff and the teachers for class trips and field trips outside of the school.

Student's NAME:_____ GRADE:_____ BIRTHDATE: _____

Student's NAME: _____ GRADE:_____ BIRTHDATE: _____

Student'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 ☐

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: _____

(*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 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)

Child's Name_____ Child's Name_____ Child's Name_____

Dental Exam Date_____ braces Y / N	Dental Exam Date_____ braces Y / N	Dental Exam Date_____ braces Y / N
Eye Exam Date_____ Contacts or Glasses	Eye Exam Date_____ Contacts or Glasses	Eye Exam Date_____ Contacts or Glasses
Allergy _____	Allergy _____	Allergy _____
Allergic Reaction_____	Allergic Reaction_____	Allergic Reaction_____
Medication_____	Medication_____	Medication_____

OTHER HEALTH CONDITION: Please list any conditions such as heart disease, diabetes, epilepsy, severe allergies, or any chronic condition, etc. in order to provide medical care to your child. List any medical/surgical care your child has received during the past year:

Please note: this information will be shared as needed with school faculty. If you DO NOT want this shared please indicted below and contact the school nurse.

Name of Child: _____ Health Condition:_____

Doctor_____ Telephone_____

Dentist_____ 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.

I hereby consent to the release/sharing of medical information for my child to appropriate school personnel to alert staff of any potential medical emergency. I also consent to the school nurse and physician sharing information on my behalf such as faxing of medical records, sports physical paperwork, immunization records, school notes, etc.

_____ _____

Signature of Parent(s)/Guardians Date