

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

ESTELL MANOR SCHOOL
EMERGENCY CARE INFORMATION

School Year: 2020/2021

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: _____

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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 indicated 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