EMERGENCY MEDICAL INFORMATION FOR SCHOOL YEAR 2023-24 PLEASE RETURN TO NURSE

Student's Last Name:_____First Name:_____ Grade:_____

Gender:_____ Date of Birth:_____

Address:_____Town:_____Home Phone #_____

Parent/Guardian #1_____Phone # _____Work Phone#_____

Parent/Guardian #2_____Phone # _____Work Phone#_____

Email #1 _____ Email #2 _____

Please designate two local people who we can contact in the event you cannot be reached.

Emergency Contact Name: _____Emergency Contact # _____

Emergency Contact Name: _____Emergency Contact # _____

Does your child have health insurance? ❒ No ❒ Yes - Name of insurance _____

If no, do you grant permission to the school to release your name, address, and Free/Reduced lunch information to the NJ FamilyCare Program to contact you about health insurance? 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. ❒ No ❒ Yes

Signature: _____ Printed Name: _____ Date: _____

This section to be completed for all students

If your child is involved in a medical EMERGENCY, the school authorities will arrange for transportation for your child to the nearest hospital. Parents are responsible for the financial obligation for such emergency care and transportation to the hospital.

Allergies:_____Reaction: _____

Known condition which may cause a medical emergency:_____

Medical concerns the nurse should be aware of:_____

_____

List **all** medications your child **takes at home**:_____

_____

List **all** medications your child **will need in school**:_____

Physician's Name:_____Phone #_____Preferred Hospital_____

IMPORTANT - PLEASE NOTE Parents/Guardians of students with severe allergies, asthma, diabetes or seizures, and/or who require medications during school hours, must contact the school nurse on the first day of school to receive an asthma action plan, allergy emergency health care plan, seizure action plan, or a medication permission form for the doctor to complete. Forms may also be found at https://www.jefftwp.org/Page/64. Students who will require medication(s) while on a field trip are to contact the school nurse 4 weeks prior to the trip.

I give consent for my child _____for the following:

1. Health information/medications to be shared with my child's teachers/staff when appropriate ☐ Yes ☐ No
2. Scoliosis screening by the school nurse **(grades 5, 7, 9, & 11**). ☐ Yes ☐ No
3. The School Nurse may contact my child's physician regarding health information & medications when appropriate ☐ Yes ☐ No

PARENT/GUARDIAN SIGNATURE (Required) _____Date:_____