## WEST MILFORD TOWNSHIP PUBLIC SCHOOLS

## **Emergency Information Form**

**Dear Parent or Guardian**: To serve your child in case of sudden illness, it is necessary to provide the following information for emergency purposes. Please correct any outdated information and complete <u>all</u> missing information. Write "N/A" if the area is not applicable or information is not available. Sign and return to the main office. This form will eliminate the need to complete multiple emergency cards.

	not available. Sign and return to the	main office. This form w	in chiminate the nec	tu to complete in	unipie emergency	carus.		
ID#								
Last Name:	First:	Middle:		DOB:				
Address:		School:						
City:		Grade:						
Home Telepho	one:	Teacher/H.R	:					
Name			Address Telephon			e Cell		
Mother:	Hoi							
E.41	· · · · · · · · · · · · · · · · · · ·	rkplace:	<u> </u>	-	<del></del>			
Father:	Hoi Wo				<del></del>			
E-mail Addres		rkplace:						
List two neigh	bors or nearby relatives who will assi	ume temporary care of you	r child.					
Name	•	Name						
Home Addres	S	Home A	ddress					
Work Address		337l. A -						
Telephone Ho	me		Telephone Home					
Telephone Wo	ork	<u>Telephor</u>	Telephone Work					
Cell Number		Cell Nun	Cell Number					
Relationship		Relations	Relationship					
Does child ha	ve Health Insurance? Yes No		as Health Insurance	Changed? Yes	No			
Yes	If Yes, name of Insurance Company:							
No	NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents.  For more information call 800-701-0710 or visit <a href="https://www.njfamilycare.org">www.njfamilycare.org</a> to apply online You may release my name address to the NJ FamilyCare Program to contact me about health insurance.  Signature  Printed Name:  Date:							
	Written consent required to release your name 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.						Y	N	
Does your child attend daycare? Yes No if Yes, Where					Braces:			
List Medical Conditions:					Glasses:			
Medications (taken @ home and school):					Hearing Aides:			
List Allergic /								
List Medical I								
I agree to have	e my child screened for scoliosis? For	Grades 5-12 (Please initial	al)					
	Name	Telephone		Sibling Name	School Attendir	ng		
Doctor:								
Hospital:								
I, the undersig	ned, do hereby authorize officials of	New Jersey Public Schools	to contact directly	the persons nan	ned on this card and	d do		
authorize the	named physicians to render such treat	ment as may be deemed no	ecessary in an emer	gency, for the he	ealth of said child.			
	at physicians, other persons named on is deemed necessary in their judgm			e school officials	are hereby authori	zed to	take	

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Date:

Signature: