MONROE TOWNSHIP PUBLIC SCHOOLS
EMERGENCY FORM

DEAR PARENTS:

To update our files, would you please fill out the following questionnaire and return it with your child to his/her school nurse as soon as possible. If your child has a medical problem, is on medications, or has special medical needs, by signing this form you are giving permission to share the information below with the school nurse and any other staff member both you and the nurse believe are appropriate. If you want all information to remain confidential, please speak directly to your school nurse.

CHILD'S NAME: _____
(last) (first) (middle)

MAILING ADDRESS: _____
(street) (town) (zip)

HOME PHONE: (_____) _____ DATE OF BIRTH: _____ SEX: _____

PRIMARY LANGUAGE SPOKEN AT HOME: _____

GRADE: _____ TEACHER: _____ (H/R#): _____

NAME OF PARENT OR GUARDIAN:

MOTHER'S NAME: _____ CELL # _____

MOTHER'S OCCUPATION: _____ BUSINESS PHONE: _____

MOTHER'S E-MAIL ADDRESS: _____

FATHER'S NAME: _____ CELL # _____

FATHER'S OCCUPATION: _____ BUSINESS PHONE: _____

FATHER'S E-MAIL ADDRESS: _____

OTHER CHILDREN IN FAMILY:

NAME: _____ BIRTH DATE: _____

NAME: _____ BIRTH DATE: _____

NAME: _____ BIRTH DATE : _____

IN CASE OF EMERGENCY AND PARENT OR GUARDIAN CANNOT BE REACHED *PLEASE LIST A LOCAL PERSON*

CALL #1 _____
NAME

ADDRESS

(_____)
TELEPHONE #

RELATIONSHIP

CALL #2 _____
NAME

ADDRESS

(_____)
TELEPHONE #

RELATIONSHIP

PLEASE COMPLETE BOTH SIDES OF THIS FORM

MEDICAL INFORMATION

NAME OF FAMILY PHYSICIAN _____

TELEPHONE # (_____) _____

NAME OF FAMILY DENTIST _____

TELEPHONE # (_____) _____

HOSPITAL PREFERENCE _____

PLEASE LIST BELOW ANY MEDICAL PROBLEMS, FOOD ALLERGIES, AND/OR MEDICATIONS NEEDED.

_____

_____

_____

PLEASE LIST ANY NON-ROUTINE MEDICAL/SURGICAL CARE CHILD HAS RECEIVED IN THE LAST YEAR:

_____

_____

_____

PLEASE INDICATE IF THERE ARE ANY SPECIAL CUSTODY CIRCUMSTANCES THAT THE SCHOOL NURSE SHOULD BE AWARE OF CONCERNING YOUR CHILD. IF YOU ARE NOT THE NATURAL PARENT, PLEASE PROVIDE THE SCHOOL WITH A COPY OF ANY LEGAL DOCUMENTATION GIVING YOU LEGAL GUARDIANSHIP.

_____

_____

_____

INFORMATION TO BE SHARED WITH:

PRINCIPAL/VICE PRINCIPAL Yes / No GUIDANCE COUNSELOR Yes / No

PHYSICAL EDUCATION TEACHER Yes / No ACADEMIC STAFF Yes / No

OTHER Yes / No _____

PARENT/GUARDIAN'S SIGNATURE _____

_____

DATE

DOES THE CHILD HAVE HEALTH INSURANCE?

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 www.njfamilycare.org to apply on line. 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).