

**North Haledon School District
Memorial School**

ID# _____
Last Name _____ First _____ Initial _____
Address _____ Date of Birth (M/D/Y) _____
City _____ Grade _____
Home Tel () _____ Teacher/HR _____

To Parent/Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for emergency calls:

Name	Address	Telephone
Mother _____	_____	Home: _____ Work: _____
Father _____	_____	Home _____ Work _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

Name _____ Name _____
Tel: Home _____ Cell _____ Tel: Home _____ Cell: _____
Relationship _____ Relationship _____

Please list other children attending New Jersey Public Schools: (Name/School)

____ Please check this box if there has been a name change of parent/guardian, address or telephone number.

Please complete the reverse side of this form, sign and date. This form will be kept in the Health Office of the School.

Does 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 1-800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to the NJFamily Care 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).

List any medical/surgical care your child has received during the past year.

Dental Exam	_____	_____	_____
	Date	Braces	
Eye Exam	_____	_____	_____
	Date	Contacts	Glasses
Allergy	_____	_____	
	Kind	Medications	
Allergic Reaction	_____	_____	
	Date	Medications	
Immunization/Tetanus	_____	_____	
	Date	Type	
Restrictions	_____		
	Type		
Doctor	_____	Telephone	_____
Dentist	_____	Telephone	_____
Hospital	_____	Address	_____
	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 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 actions 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.

Signature of Parent(s)/Guardian _____

Date _____

