OCEAN CITY SCHOOL DISTRICT
OCEAN CITY, NEW JERSEY 08226
SCHOOL HEALTH SERVICE

EMERGENCY INFORMATION FORM

Please return the completed form to the school nurse during the first week of school in September – this information is very important as we may need to contact you when your child is unable to provide it in an emergency situation

PLEASE COMPLETE AND SIGN BOTH SIDES OF THIS FORM

NAME____GRADE _________

MAILING ADDRESS____

CITY____STATE_________ZIP CODE_______________

BIRTH DATE____________________________ HOME PHONE_________________ CELL PHONE__________________

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

FATHER'S NAME____CELL PHONE____________________

FATHER'S EMPLOYER____WORK PHONE____________________

MOTHER'S NAME____CELL PHONE____________________

MOTHER'S EMPLOYER____WORK PHONE____________________

****NOTE:** Please call this phone number first for attendance, illness, etc. ______________________________

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

1.____PHONE#_________________Relationship___________________________

2.____PHONE#_________________Relationship___________________________

If there has been a change of parent/guardian, address or telephone number please check here: ________

Please list other children attending New Jersey Public Schools [Name(s), Age(s), School(s)]:

____

____

INSURANCE INFORMATION:

Does child have Health Insurance?

Yes: ____ If yes, name of company:____

No: ____ If no, please see information below!

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 Family 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)

(Please turn form over and complete and sign other side)

MEDICAL INFORMATION:

PLEASE EXPLAIN ALL "YES" ANSWERS BELOW:

Have you ever been hospitalized?_____ If yes, when and for what? ___________________________________

____

Have you ever had surgery?____ If yes, when and what type? ____

____

Are you presently on any medication?____ If yes, what kind?____

Have you ever had any difficulty in gym class caused by a health problem? (ex. breathing difficulty, joint or chest pain)

Y or N – If yes – please explain:____

Do you have asthma?________ If yes, do you carry an inhaler?________ Nebulizer treatments?______________

Have you ever had a seizure?_________ If yes, how frequently?___________________________ When was your last

seizure?_________________________________

Does your child have any other illnesses or problems that we should be aware of? If yes, please list____________

____

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) Do they have an epi-pen (circle)? Yes No

Recent Immunizations/Boosters ____________________ (date) ___________________________ (type)

Restrictions(type)____

Doctor ____Telephone #___________________

Dentist ____ Telephone #___________________

Hospital ____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.

_________________________________ _________________________

Signature of Parent/Guardian Date

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