

**ORADELL PUBLIC SCHOOL DISTRICT
STUDENT EMERGENCY CARD 2013-2014**

ID # _____
Last Name _____ First _____ Initial _____ Date of Birth (MM/DD/YYYY) _____
Address _____ School _____
City _____ Zip _____ Grade _____
Home Phone (_____) _____ Teacher/H.R. _____

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.

Parent/Guardian 1 Name _____ Relationship _____
Phone Numbers: Home (_____) _____ Cell (_____) _____ Work (_____) _____ Email _____

Parent/Guardian 2 Name _____ Relationship _____
Phone Numbers: Home (_____) _____ Cell (_____) _____ Work (_____) _____ Email _____

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

Neighbor/Relative 1 Name _____ Address _____
Phone Numbers: Home (_____) _____ Cell (_____) _____ Work (_____) _____ Email _____

Neighbor/Relative 2 Name _____ Address _____
Phone Numbers: Home (_____) _____ Cell (_____) _____ Work (_____) _____ Email _____

Please list other children attending Oradell Public School (Name, Grade and Teacher)

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

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

NO My child **does not** have health insurance. 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).

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

YES My child has health insurance.

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

Dental Exam _____

Date

Braces

Eye Exam _____

Date

Glasses /Contacts

Allergy _____

Kind

Medications

Allergic Reaction _____

Date

Medications

Immunizations/Tetanus _____

Date

Type

Restrictions _____

Type

Doctor _____ Phone _____

Dentist _____ Phone _____

Hospital _____ Phone _____

Hospital Name/Address

I, the undersigned, do hereby authorize officials of the Oradell Public School District to contact directly the person(s) 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/guardians 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. Furthermore, I grant permission for the School Nurse to share my child's health information with school personnel.

Signature of Parent(s) / Guardian(s) / Date

Parents/Guardians, please complete and return one form for each child attending Oradell Public School to your child's teacher. Please proofread to ensure that all information is accurate. Thank you.