Oradell Public School - Student Emergency Card 2015/2016

Last Name _____ First Name _____ Grade ____ Homeroom Teacher _____

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

Parent /Guardian 1 Name _____ Phone Numbers (H) _____ (C) _____ (W) _____

Parent /Guardian 2 Name _____ Phone Numbers (H) _____ (C) _____ (W) _____

Neighbor/Relative Name _____ Phone Numbers (H) _____ (C) _____ (W) _____

Please list other children attending OPS

(First Name, Homeroom Teacher)

1) _____, _____

2) _____, _____

3) _____, _____

Health Insurance

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

☐ YES My child has health insurance

☐ 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.

Medical/Surgical

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

Dental Exam Date: _____ Braces: Yes No

Eye Exam Date: _____ Glasses/Contacts: Yes No

Allergy Type: _____ Medications: _____

Allergic Reaction Date: _____ Medications: _____

Immunizations Date: _____ Type: _____

Restrictions Type: _____

Doctor _____ Phone _____

Dentist _____ Phone _____

Hospital _____ Phone _____

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 district responsible for the emergency care and/or transportation of said child. Furthermore, I grant permission for the School Nurse to share my child's health information with school personnel.

_____ _____

Signature of Parent(s) / Guardians(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.