

Please Print

Student Emergency Information

Last Name		First Name	Middle	
Birth Date	Home Phone Number			
Street Address		City	State	Zip

TO THE PARENT OR GUARDIAN: It is essential that the school is able to reach you or a designee in the case of early dismissal, accident or sudden illness, or other important occurrence. Please furnish complete information.

	Parent/Guardian 1	Parent/Guardian 2	Parent/Guardian 3
Name			
Relationship			
Home Address			
Home Phone			
Cell Phone			
Work Phone			
Email Address			
Employer Name			
Work Address			

In case of an unscheduled early dismissal or if my child is sick, the following neighbors or nearby relatives, who are available during the day, have agreed to care for my child if I cannot be contacted. My child may be released to the supervision of the listed person(s), who have my permission to pick up my child if I cannot be reached.

	Emergency Contact 1	Emergency Contact 2	Emergency Contact 3
Name			
Relationship			
Daytime Phone			
Cell Phone			
Address			

Siblings in this school

Name: _____ Grade: _____ Name: _____ Grade: _____

Name: _____ Grade: _____ Name: _____ Grade: _____

Name: _____ Grade: _____ Name: _____ Grade: _____

I have discussed with my child the procedures he/she should follow in the event of an unscheduled early dismissal or emergency dismissal from school.

Parent/Guardian Signature

Date



Student Emergency Information

Health Information

Please Print

Last Name		First Name	Middle
Date	Family Physician		Phone #
Preferred Emergency Hospital			Phone #

Health Conditions -List any health conditions such as asthma, diabetes, seizure disorder, severe allergies, eye or ear problems, or any chronic health condition, etc., which your child may have. This information will only be shared with appropriate school personnel on an as-needed basis.

Medications currently taking: _____

Recent Surgery (please specify): _____

I (we), the undersigned do hereby authorize the staff of the School District of Winfield Township to contact directly the persons named on this card. In the event other persons named on this card, or parents/guardians cannot be contacted, the school staff is hereby authorized to take whatever action is deemed necessary, in their judgment, for the health of my child. I (we) agree to be responsible for the costs of any emergency care, treatment and/or transportation; and I (we) hereby release the district from liability pertaining to any emergency care, treatment, and/or transportation.

Parent/Guardian Signature

Date

Does your 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 about health insurance.

Printed Name: _____

Signature: _____ Date: _____

Written consent required pursuant to 20 U.S.C. § 1232g (b)(1) and 34 C.F.R. 99.30 (b).