

Please check if home address or phone number is different from last year.

School Nurse Emergency Card/Monroe Township Public Schools

School: _____

Year: _____

Student: _____ M – F Birth date: _____
(Last) (First) (MI) Eye color: _____

Bus # : _____

Address: _____ Home Phone: _____

Please indicate whom child lives with: _____

Mother's/Guardian's name: _____ Cell: _____

Employer: _____ Employer Phone: _____

E-mail: _____

Father's/Guardian's name: _____ Cell: _____

Employer: _____ Employer Phone: _____

E-mail: _____

It is absolutely necessary that we contact you during the school day in case of accident or sudden illness involving your child. When neither parent can be reached, please list neighbors/relatives **NEARBY** who may assume temporary care of your child and who have access to transportation.

*Please indicate which number is the best to call first.
The information on this card is not used to update Global Connect.*

1. Name _____ Relationship _____

Address _____ Phone _____

2. Name _____ Relationship _____

Address _____ Phone _____

3. Name _____ Relationship _____

Address _____ Phone _____

4. Name _____ Relationship _____

Address _____ Phone _____

Please list all brothers/sisters and school they presently attend:

Name Grade School

1. _____
2. _____
3. _____
4. _____
5. _____

IMPORTANT INFORMATION ON REVERSE SIDE - PLEASE COMPLETE

K/AM K/PM

H.R. TEACHER/GR.

First

Last

STUDENT NAME

For the safety of your child, we must update their health records yearly. This form is necessary to keep their records current. It must be completed, signed, and returned IMMEDIATELY. If you have any questions, please call the nurse at your child's school. Please print all information. A separate form is required for each child.

CONFIDENTIAL MEDICAL INFORMATION

Please list any serious injuries, illnesses, surgeries or medical conditions (with dates) that your child has experienced. Please list all health conditions/medical problems EVEN if listed in previous years.

Please list any medications your child takes on a routine basis. _____

Any physical limitations? Y N Glasses _____ Contact Lenses _____

Is student allergic to: **Food** _____ **Drugs** _____ **Insect Bites** _____ **Nuts** _____

If yes, please indicate the reaction expected, any special instructions pertaining to immediate medication need: _____

Is an Epi-Pen required? Y N

Do you have any comments to add – medical or otherwise: _____

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

This medical information will be shared with the necessary school staff. *If you do not want the information shared please initial here:* _____. This form may be returned in a sealed envelope. **Please label with your child's name and health update form.**

Does child have health insurance? **Yes** _____ **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 online.

If your child does not have health insurance, may we share your free/reduced lunch information with NJ FamilyCare?

Yes _____ **No** _____

Signature: _____ **Printed Name:** _____ **Date:** _____

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

I hereby grant permission that in case of an emergency, this student may be transported to the hospital for treatment if necessary. (Every effort will be made to contact you prior to your child being taken.)

Signature of Mother/Guardian

Signature of Father/Guardian