Upper Township School District
2010-2011 NJ Family Care Emergency Medical Form
(please complete both sides for each child)

Student ID (Assigned by the District): _____

Last Name:_____First Name:_____Initial:_____
Date of Birth (MM/DD/YYYY):_____
School:_____Grade:_____Teacher:_____
Address:_____
City:_____Zip:_____
Home Telephone: (_____)_____

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

Name(s) of Legal Guardians:_____

Mother's Last Name:_____First Name:_____
Address:_____
City:_____Zip:_____
Home Telephone: (_____)_____Cell #: (_____)_____
Employer's Name:_____Work #: (_____)_____

Father's Last Name:_____First Name:_____
Address:_____
City:_____Zip:_____
Home Telephone: (_____)_____Cell #: (_____)_____
Employer's Name:_____Work #: (_____)_____

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

Last Name:_____First Name:_____Relationship:_____
Address:_____
City:_____Zip:_____
Home Telephone: (_____)_____Cell #: (_____)_____
Employer's Name:_____Work #: (_____)_____

Last Name:_____First Name:_____Relationship:_____
Address:_____
City:_____Zip:_____
Home Telephone: (_____)_____Cell #: (_____)_____
Employer's Name:_____Work #: (_____)_____

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

Yes:_____ Name of Insurance Company:_____

No:_____ NJ FamilyCare provides free or low cost health insurance
Please call 800-701-0710 or visit www.njfamilycare.org to apply

I give the District permission to release my information to the NJ FamilyCare Program who will then contact me regarding insurance

Printed Name:_____Date:_____
Signature:_____
Written consent required pursuant to 20 U.S.C., 1232g (b)(1) and 34 CFR 99.30 (b)

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

Last Dental Exam performed on:_____ Braces: Y or N
Last Eye Exam performed on:_____ Contacts: Y or N Glasses: Y or N
Allergies:_____Medications:_____
Last Allergic Reaction on: _____Medications:_____
Last Immunization/Tetanus given on: _____
Medical Restrictions:_____

Doctor:_____Telephone #: (____)_____
Dentist:_____Telephone #: (____)_____
Hospital:_____

I, the undersigned, do hereby authorize officials from the Upper Township School District to contact directly the persons named on this form 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, school officials are hereby authorized to take whatever action is deemed necessary for the health of said child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____Date:_____