**SAYREVILLE PUBLIC SCHOOLS** **STUDENT EMERGENCY CARD**

School Year School Bus Route Grade HR Teacher

Student's Name_____ Date of Birth: (MM/DD/YYYY)_____
LAST FIRST

Male___Female___ (Check One)

Student's Address_____Home Phone_____

Name/Address of Mother/Guardian:
Name/Address of Father/Guardian:

Work Address / Tele# (Mother) Work Address / Tele# (Father)

EMAIL Address Mother EMAI L Address Father

Cell Phone: Mother Cell Phone: Father

EMERGENCY NUMBERS Contacts who can pick up child if parents are not available:

Name_____Relationship Phone#_____Cell#_____

Name._____.Relationship_____.Phone#_____Cell#_____

Name_____Relationship Phone#_____Cell#_____

Students Lives with (check 1only): Mother & Father___ Mother only___ Father only___ Guardian only___

Name(s) of any adults who **MAY NOT** sign the child out of school._____

Please list any other Siblings and the School(s) they attend:

Full Name._____School._____Grade_____

Full Name._____School._____Grade_____

Medication-Based ALLERGIES (Please list any medications to which your child is allergic):

Was **EPIPEN** ever used? YES _____ NO _____ When _____

FOOD ALLERGIES (Please list any foods to which your child is allergic): _____

OTHER ALLERGIES: (Please list any other substances to which your child is allergic): _____

My Child Needs a Peanut / Tree-Nut Free Environment / Lunch Table: Yes___ No____

Does Child have Asthma? YES ____ NO____Does Child take Medication? YES __ NO ___
What MEDS? At Home? ____At School?____Other Medical Concerns? (Please List):

_____

Doctor's Name _____ Telephone # _____ Preferred Hospital

**"You may release my name and address to the NJ Family Care Program to contact me about health insurance."**

**Parent's/Guardian's Signature: _____Printed Name:_____Date:_____**

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

**NOTE: The Emergency Squad will determine hospital in an emergency.**
"I, the undersigned parent/guardian, do hereby authorize the officials of the Sayreville Public School District to contact directly the persons named on this card and do authorize the named physician(s) to render such treatment as may be deemed necessary in an emergency, for the health of my child. In the event that the parent(s), physician(s) or other persons named on this card 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. My child may be taken to the hospital for treatment and the hospital may administer emergency medical treatment, if necessary. I will not hold t he school district financially responsible for the emergency care and/or transportation of said child."
**Parent's/Guardian's Signature: _____ Date:**
"I give my permission for the school nurse to contact my child's doctor(s), should the need arise."
**Parent's/Guardian's Signature: _____ Date:**
"I give my permission for the school nurse to share critical health information with the appropriate faculty, as needed."
**Parent's/Guardian's Signature: _____ Date: _____**