

The information below MUST BE COMPLETED. This information is required by the State of New Jersey

Student Name: _____ Teacher: _____

Military Indicator

A new element, Military Indicator, will need to be collected. This element serves an indication that the student’s parent or guardian is on Active Duty, in the National Guard, or in the Reserve components of the United States military services.

Please check the one that applies:

_____ 1 = Not Military Connected – Student is not military-connected.

_____ 2 = Active Duty – Student is a dependent of a member of the Active-Duty forces (full-time) Army, Navy, Air Force, Marine Corps, or Coast Guard.

_____ 3 = National Guard or Reserve – Student is a dependent of a member of the National Guard or Reserve Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard).

_____ 4 = Unknown – It is unknown whether or not the student is military-connected.

Health Insurance

Does Child have Health Insurance?

_____ Yes. Name of company _____ (Required)

_____ No. NJ Family Care 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.

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

Signature: _____ Printed Name: _____ Date: _____

In an emergency, per Gloucester County Ambulance, your child will be taken to the nearest hospital.

Please check one of the following hospitals below.

Crozer Keystone

Inspira Medical Center

If your child has any NEW/ACTIVE/CHRONIC medical problems that the nurse should be aware of, Please call your child’s school nurse.

*******PER SWEDESBORO-WOOLWICH SCHOOL DISTRICT POLICY*******

If medicine of any kind is to be given by the school nurse, **MEDICATION MUST BE DELIVERED TO THE SCHOOL NURSE IN ITS ORIGINAL LABELED CONTAINER BY THE STUDENT’S PARENT/GUARDIAN.** Medication must be accompanied by the parent/guardian’s written request for its administration and by the physician’s written and signed statement of the medication’s name, the purpose of its administration to the specific student for whom it is intended, its proper timing and dosage, its possible side effects, and the time when its use will be discontinued.

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I, the undersigned do here by authorize officials of New Jersey Public School to contact directly the person(s) named on this sheet. If they cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Parent/Guardian Signature: _____ Date: _____