Grade _______ Home_______

ANDOVER REGIONAL SCHOOL DISTRICT
EMERGENCY REFERENCE CARD

SID#_________________
(office use only)

Please complete both sides of this card.
Please contact school nurse if information changes on this card.

Pupil ______________________________ Date of Birth ______________________

Address ____

Home Phone __________________________ Cell Phone(s) ____________________

Father's Name ________________________ Mother's Name ____________________

Father's Place of Business _______________ Mother's Place of Business _____________

Father's Business Phone _________________ Mother's Business Phone _______________

If parents are unavailable, please contact:

Name ______________________________ Phone ______________________
Name ______________________________ Phone ______________________
Physician ___________________________ Phone ______________________
Hospital ____________________________ Phone ______________________

I, the undersigned, do herby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physician to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that the physician, other persons named on this card, or parents 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. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent(s)/Guardian(s) ______________________________ Date ______________

Does your child have Health Insurance?
Written consent required pursuant to 20 U.S.C. 1232g (b)(1) and 34 C.F.R. 99.30 (b).

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

Signature ____________________ Printed Name ______________________ Date ____________

Please list any chronic medical conditions (asthma, diabetes, limitation, restrictions on mobility, etc)

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Name and dosage of medication(s) your child must take on a daily basis during school hours, or medication taken as needed (inhaler for asthma, etc)

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All medications for students must be delivered to and from school by parents or designated adults.
All medication must be in the original container. For the safety of all students, medications are never to be in a student's possession.
Please list all allergies (food, insect sting, medication, animals, environmental, etc).

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Type of reactions ______________________ Treatment/medication, if any ______________________

The school nurse hereby has my permission to dispense the following medications to my child in age appropriate doses:
Acetaminophen (Tylenol pain relief) Yes _____ No _____ Ibuprofen (Advil pain relief) Yes _____ No _____
Throat Lozenge (cough/sore throat) Yes _____ No _____ Antacid/Tums (stomach upset) Yes _____ No _____
Parent/Guardian Signature ______________________________ Date ______________________

I give permission to the school nurse to share pertinent medical information with my child's teacher(s) and appropriate school staff.
Parent/Guardian Signature ______________________________ Date ______________________