STUDENT CONTACT INFORMATION

Notify the Nurse and Guidance Counselor of any changes in contact information.

Please complete both sides of card

Student's Name:_____ **Date of Birth**_____ **M**____**F**_____ **Grade**_____ **H.R.#**_____

Address:_____ **Town/Zip**_____

Home Phone Number_____

Parent/Guardian (Please provide information on parent/guardian with whom the child lives.)

1. **Full Name**_____ **Cell Phone ( )**_____

   Email address_____

   Employer_____ **Work No. ( )**_____

   Relationship to child (please circle) Mother Father Legal Guardian Other (specify)_____

2. **Full Name**_____ **Cell Phone ( )**_____

   Email address_____

   Employer_____ **Work No. ( )**_____

   Relationship to child (please circle) Mother Father Legal Guardian Other (specify)_____

List local relatives, neighbors, or friends who would assume temporary care of your child if you cannot be reached:

Name_____ Phone No. ( )_____Work/Cell No.( )_____ Relationship_____

Name_____ Phone No. ( )_____Work/Cell No.( )_____ Relationship_____

Primary Physician:_____**Physician's Phone:**_____

*****In case of an accident or serious illness, reasonable efforts will be made to contact the student's parent/guardian. If necessary, the Primary Care Physician and/or 911 will be called and the student will be sent to the nearest hospital. Please notify the Student Health Office if there are changes in this information*.**

Information for Parent/Guardian with whom the child does NOT live.

1. **Full Name**_____ **Home Phone ( )**_____
   Address_____ **Cell Phone ( )**_____
   Email address_____
   Employer_____ **Work No. ( )**_____

Relationship to child (please circle) Mother Father Legal Guardian Other (specify)_____

2. **Full Name**_____ **Home Phone ( )**_____
   Address_____ **Cell Phone ( )**_____
   Email address_____
   Employer_____ **Work No. ( )**_____

Relationship to child (please circle) Mother Father Legal Guardian Other (specify)_____

Please provide the counseling department with all updated court orders if applicable.

Does child have Health Insurance? ☐ **Yes** **Name of insurance company**_____
☐ **No ***

*** NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents.**
Call 800-701-0710 or visit www.njfamilycare.org to apply online.

☐ **You may release my name and address to NJ Family Care program to contact me about health insurance.**
☐ **Do NOT release my name and address to NJ Family Care program.**

Revised: 9/1/16

STUDENT MEDICAL INFORMATION

Notify the Nurse of any changes in medical information.

Please complete both sides of card

STUDENT NAME_____ **M**____ **F**____ **DATE OF BIRTH** _____
GRADE _____

CURRENT MEDICAL CONCERNS

Please check below any health condition(s) your son/daughter may have: ☐ **My son/daughter has no health conditions.**

☐ ADD/ADHD ☐ Epilepsy/Seizures (see below) ☐ Orthopedic Disorder ☐ Nosebleeds ☐ Allergies (see below) ☐ Cardiac Problems (see below)

☐ Mental/Emotional Disorder ☐ Menstrual Cramps ☐ Asthma (see below) ☐ Diabetes* ☐ Migraine Headaches ☐ Hearing Loss ☐ Concussion within one year

***State Law requires a Diabetes Medical Management Plan to be completed. Forms available at www.lrhsd.org under Parent tab. Click on Medical Information**

☐ Other _____

Allergies	What is he/she allergic to: ☐ Latex ☐ Animals ☐ Insects ☐ Food ☐ other_____ *Is emergency medication needed at school for allergies? ☐ Yes ☐ No Epi –Pen? ☐ Yes ☐ No If Yes, name of medication:_____ Date of last reaction:_____ Check the type of allergic reaction that occurs: ☐ Hives ☐ Swelling ☐ Difficulty Breathing ☐ Other _____ ****State Law requires Physician Orders and Parent Permission for epinephrine administration. You must also provide the school with an epinephrine auto-injector in addition to the one your child carries. Forms available at www.lrhsd.org under Parent tab. Click on Medical Information.**
Asthma	Date of last episode:_____ List triggers:_____ Medication is needed in school: _____Daily _____Before P.E. _____Never _____When symptoms occur ****State Law requires an Asthma Treatment Plan to be completed for asthma medication including inhalers. Forms available at www.lrhsd.org under Parent tab. Click on Medical Information.**
Cardiac	Please Speciify:_____ Limitations:_____ Medication:_____ School Concerns:_____
Other	Please Speciify:_____ Limitations:_____ Medication:_____ School Concerns:_____

****Parent consent for acetaminophen (Tylenol) administration for current school year** Please check appropriate box:**

☐ YES ☐ NO

Administer to students Acetaminophen (Tylenol) 650 mg po prn q 4 hours or Acetaminophen (Tylenol) 1000 mg po prn q 6 hours for pain or fever with written consent of parent or guardian. Administration of this medication is not to exceed two consecutive days and a maximum dose of 3000 mg in a 24 hour period. I acknowledge that the school district and its employees or agents shall incur no liability as a result of administration of this medication to my son/daughter.

****All medication (including over the counter medication) to be taken during school requires a medication form to be completed by the Parent and Physician.**

Does he/she take any medication on a regular basis? ☐ Yes ☐ No
If yes, please complete the following: Name of the Medication, Dosage, Reason _____
Name of the Medication, Dosage, Reason _____
Name of the Medication, Dosage, Reason _____
Name of the Medication, Dosage, Reason _____
Name of the Medication, Dosage, Reason _____

Does he/she have any drug allergies? ☐ Yes ☐ No
If Yes, Please list:_____

I certify that the information on BOTH SIDES of this card is correct. I consent to the release of this medical information to appropriate school staff to insure the safety and learning potential of my son/daughter.

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

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

Please complete both sides of card