

**PITMAN SCHOOL DISTRICT
EMERGENCY INFORMATION AND MEDICAL CARD**

STUDENT'S NAME AND ADDRESS

ETHNICITY

Name _____ American Indian/Alaskan Native
Address _____ African American/Black
Phone _____ Asian/Pacific Islander
Caucasian/White Hispanic
Other

Birth Date _____ Age _____ Teacher: _____ Grade: _____

PARENT OR GUARDIAN (circle)

Father/Guardian Name _____ Home Phone _____

Address _____

Does the father reside with the student (yes/no) _____

Work Phone _____ Place of Employment _____

Cell Phone _____ E-mail _____

Mother/Guardian Name _____ Home Phone _____

Address _____

Does the mother reside with the student (yes/no) _____

Work Phone _____ Place of Employment _____

Cell Phone _____ E-mail _____

Siblings (include ages) of Above Named Student:

1. _____ 2. _____
3. _____ 4. _____

PERSONS OTHER THAN PARENTS WHO WILL TAKE RESPONSIBILITY FOR YOUR CHILD IF PARENTS CANNOT BE REACHED

<u>Name</u>	<u>Relationship To Student</u>	<u>Address</u>	<u>Phone</u>
1. _____			
2. _____			
3. _____			
4. _____			

_____ Check here if: **IDO NOT** grant my permission for pictures, videos of my child, or any of his/her work to be submitted to newspapers or TV stations for publication or posted on the Pitman School District website and Facebook page.

OVER→

MEDICAL INFORMATION

CHECK IF THE STUDENT HAS ANY OF THE FOLLOWING CONDITIONS:

- | | |
|---|---|
| <input type="checkbox"/> Heart Condition: Restrictions__yes __ no | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Asthma: On medication__yes __ no | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Adverse Drug Reaction | <input type="checkbox"/> Severe allergies(including food or bee stings) |
| <input type="checkbox"/> Hearing Problems: __ ear tubes __ aids | <input type="checkbox"/> Braces |
| <input type="checkbox"/> ADHD: On medication__ yes__no | <input type="checkbox"/> Vision problems: Glasses __ Contacts__ |
| <input type="checkbox"/> Other:_____ | <input type="checkbox"/> Fractures _____ year |

Please explain any of the above questions if they are checked:

My child is on the following medication:_____(*CONTACT NURSE IF NEEDED DURING SCHOOL)

Recent surgery, illnesses, or injuries and date(s):_____

Family Physician:_____ Phone:_____

Family Dentist:_____ Phone:_____

Does your child have health insurance? Yes _____ No _____

If yes, name of insurance company:_____

If no, NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 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:_____

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

In case of an **EMERGENCY** and your child has to be taken to the nearest hospital, your preference is:

_____. I give my son/daughter permission to receive emergency hospital treatment, if necessary.

I hereby give permission to release information regarding my child's health condition(s) to essential school personnel and those authorized on this emergency card who assume temporary care of my child in order to best meet the medical and health needs of my child in the school setting.

Signature of Parent/Guardian

Date