Union County Educational Services Commission
Student Emergency/Information Form
2024 - 2025 School Year

Student Information

Last Name	First Name	Middle Initial	Date of Birth

Street Address	Town or City	Zip Code

Home Phone	Cell Phone	Email Address

Mother's Name/Legal Guardian

Last Name	First Name	Email Address

Street Address (if different)	Town or City	Zip Code

Work Phone	Home Phone	Cell Phone

Father's Name/Legal Guardian

Last Name	First Name	Email Address

Street Address (if different)	Town or City	Zip Code

Work Phone	Home Phone	Cell Phone

If I cannot be reached, you have my permission to contact one of the following people who will care for my child until I'm available. Please DO NOT use the same phone numbers listed above.

1. Name _____ Relationship _____
   Home Phone _____ Cell Phone _____

2. Name _____ Relationship _____
   Home Phone _____ Cell Phone _____

3. Name _____ Relationship _____
   Home Phone _____ Cell Phone _____

_____ _____
Parent/Guardian Signature **Date**

Medical Information

Student's Last Name	First Name	Middle Initial	Date of Birth

Student's Doctor _____ Date of last physical _____

Address _____ Phone _____

In case of emergency, may we contact your child's doctor? ☐ Yes ☐ No

Please list allergies, including food and drug allergies:

_____

_____

_____

Is your child subject to seizures? ☐ Yes ☐ No

Please list dates, place(s), and reason(s) for any recent hospitalizations.

_____

_____

_____

Is your child medically excused from physical education (gym)? ☐ Yes ☐ No
Please note: State Law requires a doctor's note in order for a student to be excused from physical education classes.

I hereby give the school nurse permission to perform a scoliosis screening. ☐ Yes ☐ No
If you DO NOT give permission, a doctor's note must be sent to the school nurse with the screening results.

Please list any medications your child takes at home or in school.

Medication _____ Dosage _____ Frequency _____

Medication _____ Dosage _____ Frequency _____

Medication _____ Dosage _____ Frequency _____

Please list any additional medical/health concerns.

_____

Medical Insurance Carrier _____

Medicaid Number *(if applicable)* _____

Do you give permission to share student's medical information with his/her teacher and appropriate staff?
☐ Yes ☐ No

If your child does not have health insurance including NJ FamilyCare/Medicaid, Medicare, private or other, please contact NJ FamilyCare which provides free or low-cost health insurance for uninsured children and certain low-income parents. For more information, please visit www.njfamilycare.org to apply online or call (800) 701-0710.

If my child requires immediate medical attention because of illness or accident and I cannot be reached by telephone, I hereby authorize Union County Educational Services Commission to secure appropriate medical assistance at my expense.

Parent/Guardian Signature: _____ **Date** _____