

# Emergency Information Verification Form

Please sign as indicated. Also, please fill in any missing information and make corrections where necessary.

|  |            |  |            |
|--|------------|--|------------|
| Current School:  |            | Grade:                                       | Homeroom:  |
| Student's Name:  |            | DOB:   | Sex:       |
| Legal Residence:   |            | Mailing Address if different than residence: |            |
|  |            | Court Orders/Legal Restrictions:             |            |
| Please include company name for Work numbers, so that if your company changes phone numbers we will still be able to locate you. Emergency numbers will only be used in the event that we cannot reach at the other numbers listed. The Primary or Home Number will also be used for attendance auto-dialer. |            |  |            |
| <b>Guardian 1:</b>   |            | Primary #:                                   | E-Mail:    |
| Home:  | Home Cell: | Work:  | Work Cell: |
| <b>Guardian 2:</b>   |            | Primary #:                                   | E-Mail:    |
| Home:  | Home Cell: | Work:  | Work Cell: |
| <b>Emergency 1:</b>  |            | Primary #:                                   | E-Mail:    |
| Home:  | Home Cell: | Work:  | Work Cell: |
| <b>Emergency 2:</b>  |            | Primary #:                                   | E-Mail:    |
| Home:  | Home Cell: | Work:  | Work Cell: |
| <b>Emergency 3:</b>  |            | Primary #:                                   | E-Mail:    |
| Home:  | Home Cell: | Work:  | Work Cell: |

|  |   |
|--|---|
| <p><b>Health Information:</b></p> <p>Medical alerts/allergies:</p> <p>Receives daily medication during school hours (Y/N):</p> <p>Wears glasses and/or contact lenses (Y/N):</p> | <p>This student's health information may be shared with pertinent school staff if necessary to maintain well being and safety.</p> <p>Parent/Guardian will call the school if student will be absent or late.</p> <p style="text-align: right;">_____<br/><b>Signature</b> <span style="margin-left: 100px;"><b>Date</b></span></p> |
|--|---|

|  |                     |                       |
|--|---------------------|-----------------------|
| <b>Health care provider information</b> (for emergency treatment when we are unable to contact you): |                     |                       |
| <b>Contact Type</b>  | <b>Contact Name</b> | <b>Contact Number</b> |
| Hospital   |                     |                       |
| Doctor   |                     |                       |
| Dentist  |                     |                       |

|  |   |
|--|---|
| Does your child have health insurance coverage?    | <p>Please sign here to indicate that we have your permission to call the physicians listed or to have your child taken to the hospital when you are not available or in an emergency.</p> <p style="text-align: right;">_____<br/><b>Signature</b> <span style="margin-left: 100px;"><b>Date</b></span></p> |
| If yes, what is the name of the Insurance Company? |   |

**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](http://www.njfamilycare.org) to apply online. You may release my name and address to NJ FamilyCare Program to contact me about health insurance.

|                  |                     |             |
|------------------|---------------------|-------------|
| <b>Signature</b> | <b>Printed Name</b> | <b>Date</b> |
|------------------|---------------------|-------------|

|                                  |             |
|----------------------------------|-------------|
| For School Use Only: Student ID: | Date filed: |
| Date Updated in Database:        | Initials:   |