MOUNT ARLINGTON PUBLIC SCHOOLS

Yearly Health Insurance & Medical Updates

Does your child have Health Insurance? Yes____ No ____
If yes, name of Insurance Company:_____Policy #_____
Name of Policy Holder:_____
If No, **NJ FamilyCare** 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 FamilyCare Program to contact me about health insurance. *Written consent is required under 10 U.S.C. 1232 g(b)(1) and 34 C.FR. 99.30(b).* Yes____ No____
Signature_____ Printed Name:_____
Date_____
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List any medical/surgical care your child has received during the past year:_____
_____

Does your child have any medical problems, i.e. Asthma ___, Diabetes___, heart disease____, seizure disorder____, other_____

Does your child currently take any medications? Yes or No.
Medication(s)_____ If a medicine is to be given during school, please contact the school nurse regarding the policies for the administration in school.

Dental Exam	Date	Braces: Yes No
Eye Exam	Date	Contacts: Yes No Glasses: Yes No
Allergy Date of last reaction	Type	Medications:
Restrictions*	Please explain: ie-physical or dietary*	

Medical Doctor:	Telephone:
Dentist:	Telephone:
Preferred Hospital/Address:	

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named above and I authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of the aforesaid child. If the physicians, other persons named on this page, 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 the aforesaid child.

*I, the undersigned, understand that it is MY responsibility to notify Maschio's Food Service Provider to secure a "Safe Menu" if my child has a medical condition requiring a special diet and I choose to have them buy from the cafeteria.

I permit the School Nurse to inform the appropriate staff members of my child's medical condition and special need(s).
Yes___ No____

Parent Signature_____ Date_____