



Union County Educational Services Commission

Student Emergency/Information Form

2025 - 2026 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	Home phone	Cell phone
_____		_____	_____
Street Address		Town or City	Zip Code
_____		_____	_____
Employer	Employer's Address		Work Phone

Father's Name/Legal Guardian

_____	_____	_____	_____
Last Name	First Name	Home phone	Cell phone
_____		_____	_____
Street Address		Town or City	Zip Code
_____		_____	_____
Employer	Employer's Address		Work 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.

- Name _____ Relationship _____
Home Phone _____ Cell Phone _____
- Name _____ Relationship _____
Home Phone _____ Cell Phone _____
- 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 _____