Tuckerton Elementary School District

This form MUST be completed and submitted either electronically in OnCourse or returned to the Health Office annually

ID# _____ Last Name _____ First _____ Initial _____ DOB:(MM/DD/YYYY)_____

Address _____ Address 2 _____

City _____ Zip Code _____ Home Phone (___)_____

Grade/Teacher _____

To Parent/Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for EMERGENCY CALLS. PLEASE LIST ALL NUMBERS IN THE ORDER YOU WANT THEM CALLED

Parent/Guardian (1) Name _____ Relationship _____

Phone Numbers: Home (___)_____Work(___)_____ Cell (___)_____ Email_____

Parent/Guardian (2) Name _____ Relationship _____

Phone Numbers: Home (___)_____Work (___)_____ Cell(___)_____ Email_____

List two neighbors or nearby relatives who will assume temporary care of your child(ren) if you cannot be reached:

Neighbor/Relative (1) Name_____ Relationship

Phone Numbers: Home (___)_____Work (___)_____ Cell(___)_____ Email_____

Neighbor/Relative (1) Name_____ Relationship _____

Phone Numbers: Home (___)_____Work (___)_____ Cell(___)_____ Email_____

Please list other children attending New Jersey Public Schools (Name, Grade, School)

_____ _____

_____ _____

_____ _____

❑ **Please check this box if there has been a name change of parent/guardian, address, or telephone number**

Does this child have Health Insurance including NJ FamilyCare/Medicare, private or other?

❑ **Yes** Name of insurance company _____

❑ **No** My child **does not** have health insurance. 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 D.F.R. 99.3(b)

NJ FamilyCare provides free or low cost health insurance for uninsured child and certain low income parents.
For more information call 1-800-701-0710 or visit www.nj.familycare.org to apply online.

List any medical/surgical care your child has received during the past year:

_____

Allergy _____ _____
Kind Medications

Allergic Reaction _____ _____
Date Medications

Restrictions _____
Type

Doctor _____ Phone:_____

Dentist _____ Phone:_____

Hospital _____ Phone:_____
Hospital name/Address

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card and do authorize the named Physicians to render such treatment as may deem necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents/guardians cannot be contacted, the school officials are two 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 directly financially responsible for the emergency care and or transportation for this said child.

Signature-Parent/Guardian_____ **Date:**_____