Emergency Information Verification Form

lease 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.

Guardian 1:		Primary #:	E-Mail:
Home:	Home Cell:	Work:	Work Cell:
Guardian 2:		Primary #:	E-Mail:
Home:	Home Cell:	Work:	Work Cell:
Emergency 1:		Primary #:	E-Mail:
Home:	Home Cell:	Work:	Work Cell:
Emergency 2:		Primary #:	E-Mail:
Home:	Home Cell:	Work:	Work Cell:
Emergency 3:		Primary #:	E-Mail:
Home:	Home Cell:	Work:	Work Cell:

Health Information:

Medical alerts/allergies
Does your child require an EpiPen?
If yes, please provide doctors' orders and EpiPen.
Does your child have asthma?
If yes, please provide asthma action plan.
Receives daily medication during school hours (Y/N):
Wears glasses and/or contact lenses (Y/N):

This student's health information may be shared with pertinent school staff, if necessary to maintain well being and safety.

Parent/Guardian will call the school if student will be absent or late.

_____
Signature **Date**

Health care provider information (for emergency treatment when we are unable to contact you):

Contact Type	Contact Name	Contact Number
Hospital		
Doctor		
Dentist		

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.

_____
Signature **Date**

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

☐ **NO** My child does not have health insurance. You may release my name and address to the NJ FamilyCare 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 C.F.R. 99.30(b).

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

☐ YES My child has health insurance. If yes, what is the name of the Insurance Company?

_____

Residence	Student ID: Date Filed: Initials: