STUDENT EMERGENCY CARD - *Side 1*

NURSE'S OFFICE
Lakehurst Elementary School District 2021-2022

To Parent or Guardian: In order that the School Nurse may serve your child in case of accident or sudden illness, it is necessary that you provide the information on ***both sides*** of this card for emergency calls.

Last Name: ________________ First: ________________ Initial: ______ Today's Date: ________________
Address: ________________________________ Date of Birth: ________________
Home Telephone: ________________________ Grade: ______ Teacher: ________________

	Name	Address	Telephone
Mother/Guardian:	________________	Home: ________________	Home: ________________
		Work: ________________	Work: ________________
		Email: ________________	Cell: ________________
Father/Guardian:	________________	Home: ________________	Home: ________________
		Work: ________________	Work: ________________
		Email: ________________	Cell: ________________

List two adults who will assume temporary care of your child if you cannot be reached: These two adults should be two of your emergency contacts listed on student information.

Name: ________________	Name: ________________
Home Address: ________________	Home Address: ________________
Work Address: ________________	Work Address: ________________
Home Phone: ________________	Home Phone: ________________
Work Phone: ________________	Work Phone: ________________
Cell Phone: ________________	Cell Phone: ________________
Relationship: ________________	Relationship: ________________

STUDENT EMERGENCY CARD - *Side 2* **NAME** ________________________________

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

Yes ________ If Yes, name of insurance company: ________________________________

No ________ 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* to apply online.

. 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 34C.F.R. 99.30 (b).

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

Dental Exam	________________ date	________________ braces
Eye Exam	________________ date	________________ contacts glasses
Allergy	________________ kind	________________ medications
Allergic Reaction	________________ date	________________ medications
Immunizations/Tetanus	________________ date	________________ type
Restrictions	________________ type	

Doctor ________________________________ Telephone ________________
Dentist ________________________________ Telephone ________________

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

In the event that physicians, other persons named on this card, 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 said child.

____ ________________
Parent/Guardian Signature Date