

Westampton Township Public Schools

Emergency Information

Grade _____ Date _____

Student Name: _____ Male Female

Birthdate: _____ Birth City: _____

Birth State: _____ Birth Country: _____

Parent or Guardian #1 (in case of an emergency, this person will be contacted 1st.)

Title _____ Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email address _____

Employment _____ Work Phone _____

Child lives with this person Y N This person has legal custody Y N

Child can be released to this person Y N (If no, please include custody papers)

Parent or Guardian #2 (in case of an emergency, this person will be contacted 1st.)

Title _____ Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email address _____

Employment _____ Work Phone _____

Child lives with this person Y N This person has legal custody Y N

Child can be released to this person Y N (If no, please include custody papers)

Primary contact number for automated messaging announcements: _____

(Example: Emergencies (fire, any school threat; etc.) Preferably a number where you can be reached during the school day. This # will also be used for general messaging, ie; PTA, school/community activities, etc.

In case Parent/Guardian 1 or 2 cannot be contacted in a medical emergency, please contact the following persons in order listed:

3. Name _____ Relationship _____

Phone _____ Cell _____ Work _____

4. Name _____ Relationship _____

Phone _____ Cell _____ Work _____

5. Name _____ Relationship _____

Phone _____ Cell _____ Work _____

MEDICAL INFORMATION

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

Yes _____ If Yes, name of insurance company _____

No _____ NJ Family Care 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 & 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 C.F.R. 99.30(b).

Please note any medical/surgical conditions (asthma, heart murmur, etc.) of which we should be aware below:

Condition(s) _____ Instructions _____

Medication _____ Activity Restrictions _____

Allergic to _____ Treatment _____

Name of Family Physician _____ Phone # _____

Name of Family Dentist _____ Phone # _____

Last Eye Exam _____ Glasses/Contacts: (yes) (no) Last Dental Exam _____ Braces (yes) (no)

I, the undersigned, do hereby give permission for routine screening (height, weight, vision, hearing, blood pressure, scoliosis) to be done by the school nurse and medical information to be shared with necessary staff/faculty. In the event that parent/guardians, emergency contacts or physicians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child. I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

Signature: _____ Date: _____

Parent/Guardian

Other Members of Household:

| Name | Relationship | Age | In School | Employed |
|------|--------------|-----|-----------|----------|
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I affirm that everything on this form is true & accurate.

Parent/Guardian's Signature _____

Date _____