5-6-8

# BYRAM TOWNSHIP SCHOOLS
## STUDENT EMERGENCY INFORMATION

School Year 20___
Name & Number to call first ____________________
Grade ______ Teacher ____________________

Student Name: ______________________ (Last) ______________________ (First) ______ (MI) Sex (circle): Male Female

Home Address: ______________________ Birth date [ ][ ] ■ [ ][ ] ■ [ ][ ][ ][ ] (MM) (DD) (YEAR)

Mailing address: ______________________ City: __________ State: _____ Zip: _______

**Parent Information**

| Father/Guardian | | Mother/Guardian | |
|---|---|---|---|
| Name: | | Name: | |
| Address: | | Address: | |
| | | | |
| Employer: | | Employer: | |
| City, State: | | City, State: | |
| Home Phone | Work # | Home Phone | Work # |
| Cell # | | Cell # | |

(Note: it is important for parents/guardians to inform the office, in writing of any changes in address or phone numbers.)

Child resides with: ______________________ Any Custody issues : ______________________

**Emergency contacts:** (List neighbors or nearby relatives who will assume temporary custody of your child if you cannot be reached. PLEASE ask permission to use these names.)

Name Relationship Phone

1. ______________________
2. ______________________
3. ______________________
4. ______________________

**Note: It is important for parents/guardians to inform the Health Office, in writing of their child's health needs and/or changes during the school year.**
My child receives regular care for the following medical conditions:

- [ ] No medical condition
- [ ] Yes, **please check below:**

Allergy to (list): [ ] Food ________ [ ] Medications ________ [ ] Bee Sting ________ [ ] Other ________

[ ] Asthma [ ] Diabetes [ ] Rheumatic Heart [ ] Cancer/Leukemia [ ] Heart Disease [ ] Hearing Problems [ ] Sickle Cell Anemia [ ] Vision Problem [ ] Chronic Cough/Wheezing [ ] Hemophilia Seizures

Other: ______________________

Other health information:

- [ ] Operations or injuries (include date): ______________________
- [ ] Mediations (list): ______________________
- [ ] Other health issues or concerns: ______________________

Brothers/Sisters Names Date of birth

______________________
______________________
______________________

Physician (and number): ______________________
Dentist (and number): ______________________
Orthodontist (and number): ______________________

I, the undersigned, do hereby authorize officials of Byram Township 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 t financially responsible for the emergency care and/or transportation for said child.

Does your child have Health Insurance?

Yes _____ Name of 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.

**Please CROSS OUT the following services that you DO NOT want done for your child:**

1. Permission to share the above Special Health Concerns with the staff that meets the daily needs of my child.
2. Permission for the nurse to check that the child's spine is not curved (called Scoliosis) when they are in grade 5 and 7.
3. Permission to release my name and address to the NJ FamilyCare Program to contact me about health insurance. (Written consent required pursuant to 20 USC § 1232g (b)(1) and 34 CFR 99.30 (b).)

Signature of legal Parent/Guardian: ______________________

Date: ______________ Print name: ______________________