

# BYRAM TOWNSHIP SCHOOLS

## STUDENT EMERGENCY INFORMATION

7/11

School Year 20\_\_  
 Name & Number to call first \_\_\_\_\_  
 Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Student Name: \_\_\_\_\_ Sex (circle): Male Female  
(Last) (First) (MI)

Home Address: \_\_\_\_\_ Birth date: 

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(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): <input type="checkbox"/> Food _____ | Bee Sting _____                                |   |
| <input type="checkbox"/> Medications _____             | <input type="checkbox"/> Other _____           |   |
| <input type="checkbox"/> Asthma _____                  | <input type="checkbox"/> Rheumatic Heart _____ | <input type="checkbox"/> Sickle Cell Anemia _____     |
| <input type="checkbox"/> Diabetes _____                | <input type="checkbox"/> Cancer/Leukemia _____ | <input type="checkbox"/> Vision Problem _____         |
|  |  | <input type="checkbox"/> Chronic Cough/Wheezing _____ |
|  |  | <input type="checkbox"/> Hemophilia Seizures _____    |

Other: \_\_\_\_\_

Other health information:

Operations or injuries (include date): \_\_\_\_\_

Medications (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 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](http://www.njfamilycare.org) to apply online.

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

- Permission to share the above Special Health Concerns with the staff that meets the daily needs of my child.
- Permission for the nurse to check that the child's spine is not curved (called Scoliosis) when they are in grade 5 and 7.
- 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: \_\_\_\_\_