Emergency Contact Information

FAMILY NAME _____ **HOME PHONE**_____

First Name: _____ **Allergies:** _____ **Grade** _____

First Name: _____ **Allergies:** _____ **Grade** _____

First Name: _____ **Allergies:** _____ **Grade** _____

First Name: _____ **Allergies:** _____ **Grade** _____

Father's Name: _____ **Email:** _____

Father's Address: _____

Work Phone: _____ **Cell Phone:** _____

Mother's Name: _____ **Email:** _____

Mother's Address: _____

Work Phone: _____ **Cell Phone:** _____

If parent is not available, contact: (at least two names please)

First and Last Name	Relationship	Phone
1.		
2.		
3.		

Doctor's Name: _____ **Phone:** _____

Dentist's Name: _____ **Phone:** _____

Hospital Preference: _____

If the doctor or any person named is unavailable, permission is granted to the school to follow whatever emergency procedure is necessary.

Parent or Guardian's Signature: _____ **Date:** _____

Does your child/ren have any Health Insurance including New Jersey FamilyCare/Medicaid, Medicare, private or other?

YES____ If YES, name of insurance company _____

NO_____ NJ Family Care provides fees 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 34 C.F.R. 99.30 (b).