LOWER CAPE MAY REGIONAL SCHOOL DISTRICT

ID # _____

Last Name _____ First _____ Initial _____ Date of Birth (MM/DD/YYYY) _____

Address _____ School _____

City _____ Zip _____ Grade _____

Home Phone (_____) _____ Teacher/H.R. _____

To Parent/Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for EMERGENCY CALLS.

Parent/Guardian 1 Name _____ Relationship _____

Phone Numbers: Home (____)_____ Cell (____)_____ Work (____)_____ Email _____

Parent/Guardian 2 Name _____ Relationship _____

Phone Numbers: Home (____)_____ Cell (____)_____ Work (____)_____ Email _____

List two neighbors or nearby relatives who will assume temporary care of your child(ren) if you cannot be reached:

Neighbor/Relative 1 Name _____ Address _____

Phone Numbers: Home (____)_____ Cell (____)_____ Work (____)_____ Email _____

Neighbor/Relative 2 Name _____ Address _____

Phone Numbers: Home (____)_____ Cell (____)_____ Work (____)_____ Email _____

Please list other children attending New Jersey Public Schools (Name, Grade, School)

_____ _____

_____ _____

_____ _____

☐ **Please check this box if there has been a name change of parent/guardian, address or telephone number.**

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

☐ **NO** My child **does not** have health insurance. 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).

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

☐ **YES** My child has health insurance.

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

_____

Dental Exam _____ Date _____ Braces

Eye Exam _____ Date _____ Glasses /Contacts

Allergy _____ Kind _____ Medications

Allergic Reaction _____ Date _____ Medications

Immunizations/Tetanus _____ Date _____ Type

Restrictions _____ Type

Doctor _____ Phone _____

Dentist _____ Phone _____

Hospital _____ Hospital Name/Address Phone _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) 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/guardians 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.

_____ _____

Signature of Parent(s) / Guardian(s) **Date**