PITMAN SCHOOL DISTRICT
EMERGENCY INFORMATION AND MEDICAL CARD

STUDENT'S NAME AND ADDRESS **ETHNICITY**

Name _____ American Indian/Alaskan Native ☐
African American/Black ☐
Address _____ Asian/Pacific Islander ☐
Caucasian/White ☐ Hispanic ☐
Phone _____ Other ☐

Birth Date _____ Age _____ Teacher: _____ Grade: _____

PARENT OR GUARDIAN (circle)

Father/Guardian Name _____ Home Phone _____

Address _____
Does the father reside with the student (yes/no) _____

Work Phone _____ Place of Employment _____

Cell Phone _____ E-mail _____

Mother/Guardian Name _____ Home Phone _____

Address _____
Does the mother reside with the student (yes/no) _____

Work Phone _____ Place of Employment _____

Cell Phone _____ E-mail _____

Siblings (include ages) of Above Named Student:
1._____ 2._____
3._____ 4._____

PERSONS OTHER THAN PARENTS WHO WILL TAKE RESPONSIBILITY FOR YOUR CHILD IF PARENTS CANNOT BE REACHED

Name	**Relationship To Student**	**Address**	**Phone**
1.			
2.			
3.			
4.			

_____ Check here if: **I DO NOT** grant my permission for pictures, videos of my child, or any of his/her work to be submitted to newspapers or TV stations for publication or posted on the Pitman School District website and Facebook page.

OVER→

MEDICAL INFORMATION

CHECK IF THE STUDENT HAS ANY OF THE FOLLOWING CONDITIONS:

___ Heart Condition: Restrictions__yes __ no
___ Asthma: On medication__yes __ no
___ Adverse Drug Reaction
___ Hearing Problems: ___ ear tubes ___aids
___ ADHD: On medication__ yes__no
___ Other:_____

___Seizure Disorder
___ Diabetes
___ Severe allergies(including food or bee stings)
___ Braces
___ Vision problems: Glasses ___ Contacts____
___ Fractures _____ year

Please explain any of the above questions if they are checked:

_____

_____

My child is on the following medication:_____ (*CONTACT NURSE IF NEEDED DURING SCHOOL)_____

Recent surgery, illnesses, or injuries and date(s):_____

_____

Family Physician:_____Phone:_____
Family Dentist:_____Phone:_____
Does your child have health insurance? Yes_____ No_____
If yes, name of insurance company:_____
If no, NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and 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))

In case of an **EMERGENCY** and your child has to be taken to the nearest hospital, your preference is: _____. I give my son/daughter permission to receive emergency hospital treatment, if necessary.

I hereby give permission to release information regarding my child's health condition(s) to essential school personnel and those authorized on this emergency card who assume temporary care of my child in order to best meet the medical and health needs of my child in the school setting.

_____ _____
Signature of Parent/Guardian Date