PITMAN SCHOOL DISTRICT
EMERGENCY INFORMATION AND MEDICAL CARD
2016-2017

STUDENT'S NAME AND ADDRESS

Name ______________________________

Address ______________________________

Phone ______________________________

ETHNICITY

American Indian/Alaskan Native ☐
African American/Black ☐
Asian/Pacific Islander ☐
Caucasian/White ☐ Hispanic ☐
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