Spotswood School District
Student Information Form

Last Name_____ First _____Initial _____ Date Of Birth (Mo/Day/Year)_____
Address_____ School_____
City_____Zip_____ Grade_____
Home Telephone (____)_____

To Parent or Guardian: to serve your child in case of accident or sudden illness, it is necessary that you give the following information for emergency calls: Please note: In case of district wide, school emergencies and reverse 911 contacts the home, father/mother cell and email will be contacted. Check the boxes next to all contacts you would like general information (i.e. fundraisers) sent to:

	Name	**Telephone**		**GI**
Mother	_____	Cell_____	E-mail_____	☐
Guardian		Work_____	E-mail_____	☐
Father	_____	Cell_____	E-mail_____	☐
Guardian		Work_____	E-mail_____	☐

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

Name_____ Name_____

Home_____ Home_____
Address Address
Telephone_____ Telephone_____

Relationship_____ Relationship_____

Please indicate your response and sign below it.

☐ I authorize the school nurse to release health information on my child to pertinent school personnel.
Signature of Parent/Guardian_____Date_____

☐ I do not authorize the school nurse to release health information on my child to pertinent school personnel.
Signature of Parent/Guardian_____Date_____

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

Yes_____ If yes, name of insurance 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 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).

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

_____

Dental Exam _____ _____
Date braces

Eye Exam _____ _____
Date

Does child have any drug or food allergies? _____

Is Epipen prescribed for allergy? Yes No

Does child have asthma? Yes No

Is student taking medication for asthma? Yes No If yes, Name of medication. _____

Comments and/or Other Health Information:

_____

_____

_____

Doctor_____ Telephone_____

Dentist _____ Telephone_____

Hospital_____ Address_____ Telephone_____

I, the undersigned, do hereby authorize officials of New Jersey Public 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.

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