2023-2024
HCRHS HEALTH SERVICES – EMERGENCY INFORMATION

Student Name: _____ **Student ID:** _____
Grade: _____
Primary Address: _____ **Birth Date:** _____
Home Language:_____
City/State/Zip: _____ **Birth City:** _____
Birth State: _____
Primary Phone Contact #: _____ **Birth Country:** _____
(for school notifications)

	Note that legal guardians must provide proof of guardianship to Grade Level House Office.	
	Parent/Guardian # 1	**Parent/Guardian # 2**
Relationship to student:		
Name:		
Preferred language:		
Cell Phone #:		
Second Phone #: (landline, work, etc.)		
Third Phone #: (landline, work, etc.)		
Address: (if different from student's address listed above)	☐ **Mail communications here**	☐ **Mail communications here**
Email Address:		
Access to ASPEN Portal:	☐ **Yes**	☐ **Yes**

If the parent(s)/guardian(s) listed above are unable to be reached, please provide alternative emergency contact(s), who will assume temporary care of your child, in the event of an illness or emergency.

	Name	**Relationship to student**	**Preferred Language**	**Primary Phone #**
Emergency Contact 1:				
Emergency Contact 2:				

Does your child have Health Insurance, including NJ Family Care/Medicaid, Medicare, private or other? Yes No
If Yes, please provide the name of the insurance company. _____

If No, please be advised that 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.

Is any parent/guardian active in the military? Yes No

******* Please complete both sides of this form and return it to the principal's office *******

(Over)

Check any of the following that apply:

- ☐ **I authorize the Health Office to administer Tylenol (Acetaminophen) or Advil (Ibuprofen) to my child as needed for headaches, etc.**
- ☐ **Life Threatening Allergies (food, bee stings, medications, other)--please explain below.**

  _____

- ☐ **Epinephrine required for treatment of allergies**
- ☐ **Asthma/EIA/RAD - Requires medication/inhaler**

Name and dosage of medication your child must take, during school hours: _____
And at home: _____

If yes to the above, please consult the school nurse. Epinephrine and inhaler orders must be completed before the start of each school year.

All medications for students must be delivered to and from school by the parent or designated adult. *A doctor's note must accompany a parent's note for administration*. Medications are <u>never</u> to be in a student's possession and must be in the original container. Asthma medication and EpiPens may be in a student's possession <u>*when*</u> special consent forms <u>*have been completed*</u>, for each school year.

<u>Share Medical Alerts with Teachers and Staff</u>
In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, or the alternate contacts listed on the other side of this form, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary.

- ☑ **I agree with the above statement in case of an accident or serious illness.**

Family Physician: _____ Phone Number: _____

Family Dentist: _____ Phone Number: _____

Hospital: _____ Phone Number: _____

- ☑ **By signing below I verify that all information included on this form is true and to the best of my knowledge.**

Parent/Guardian: (please print) _____

Parent/Guardian: (signature) _____

Date: _____