ATTENTION PARENTS/GUARDIANS

Please make sure both sides of the form are filled out legibly.

NAME OF SCHOOL DISTRICT

Joseph E. Soehl Middle School

ID#_____

Last Name_____ First_____ Initial____ Date of Birth (Mo/Day/Year)_____

Address_____ School_____

City_____ Zip_____ Grade_____

Home Telephone (____)_____ Teacher/H.R._____

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:

	Name	Address	Telephone
Mother/Guardian	_____	Home _____	_____
		Work _____	_____
Father	_____	Home _____	_____
		Work _____	_____

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

Name_____ Name_____

Home/Address_____ Home/Address_____

Work/_____ Work/_____

Telephone: Home_____ Work_____ Telephone: Home_____ Work_____

Relationship_____ Relationship_____

Please list other children attending New Jersey Public Schools (Name, 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?

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 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).

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

_____

Dental Exam _____ (date) _____ (braces)

Eye Exam _____ (date) _____ (contacts) _____ (glasses)

Allergy _____ (kind) _____ (medications)

Allergic Reaction _____ (date) _____ (medications)

Immunizations/Tetanus _____ (date) _____ (type)

Restrictions _____ (type)

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 judgement, 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**