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:

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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.

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