Union County T.E.A.M.S. Charter School and High School/College Leadership Academy
Medical Emergency Form – 2016-2017

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 child have Health Insurance?

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 form 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.

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

Revised: July 2016