Grade

KINNELON SCHOOL DISTRICT

EMERGENCY REFERENCE CARD

(Please complete entire card – Front *and* Back)

PLEASE CONTACT SCHOOL IF YOUR CHILD IS ABSENT

Pupil____ ☐ **Male** ☐ **Female** **Home Phone**____________________

Address____ **Place of Birth**____________________ **Date of Birth**______________

Parent Name____ **Signature**____

E-Mail__________________________________ **Work #**__________________________ **Cell #**______________________

Parent Name____ **Signature**____

E-Mail__________________________________ **Work #**__________________________ **Cell #**______________________

Guardian Name______________________________________ **Signature**____

E-Mail__________________________________ **Work #**__________________________ **Cell #**______________________

LOCAL Emergency Contact if Parent/Guardian is Unavailable:

Name____ **Address**____

E-mail__________________________________ **Phone**__________________________ **Cell #**______________________

Physician's Name________________________________ **Telephone**____

I 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.

**************************BOTH PARENTS MUST SIGN FORM******************************

Signature____ **Date**____________________________

Signature____ **Date**____________________________

List operations, injuries, illnesses or inoculations your child had this year:-

____

____

____

Name and dosage of medication your child must take during school hours:

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____

____

Name and dosage of medication taken at home:

____

____

____

All medications, for students under age 18, must be delivered to and from school by the parents or designated adult. Medications, except for asthma medication and/or EPI-PEN are never to be in student's possession and must be in original container.

Allergy: ____

Type:____

Symptoms:____

____

Medication: ____

____

____

____

The School Nurse, at her discretion, hereby has my permission to dispense the following medications to my child:

	YES	NO
Antacid Tablet (for stomach)	☐	☐
Acetaminophen (Tylenol	☐	☐
Ibuprofen (Advil)	☐	☐

Does child have Health Insurance?

☐ **Yes. If yes, name of insurance company:**

____

☐ **No. NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For information call 800-701-0710 or visit www.njfamilycare.org to apply online.**

☐ **Yes** ☐ **No. You may release my name and address to the NJ Family Care Program to contact me about health insurance.**

☐ **Yes** ☐ **No. I authorize the release of my name address, phone number and email address to be used as a school directory and E-News newsletter.**

☐ **Yes** ☐ **No. I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimens) to be exchanged among appropriate professional staff involved in the care of my child.**

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Signature of parent or guardian **Date**

If teachers wish to cal you regarding general school matters or your child's progress may we call you at your place of business?

Prefer we did not:___________ **Calls welcome:**___________