Franklin Township School Emergency Care Form

PLEASE COMPLETE ALL INFORMATION BELOW:

Student's Name_____ Home Phone _____

Address_____ Please check if this ☐ is a new address

(Please notify the school if the above address changes during the school year)

Grade _____ **Teacher's Name** _____ **Date of Birth** _____

Please list telephone numbers at which parents can be reached.

1. _____ **2.** _____

Cell Phone Numbers:

Mom's Cell _____ **Dad's Cell** _____

Mom's Work _____ **Dad's Work** _____

EMAIL ADDRESS_____

Please list name and telephone number of two people whom we may contact in case your child becomes ill and we can't contact you.

1. _____ Phone_____

2. _____ Phone_____

List of any known allergies:_____

Please list any current health problems:_____

Is medication required: Yes_____ No_____

Does your 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 please 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).

Please indicate in the space below if there has been a divorce or separation since the previous school year. If there has been a divorce or separation and the non-custodial parent cannot sign the child out of school, legal documentation must be provided.

***PLEASE BRING CUSTODY PAPERS TO BE KEPT ON RECORD (CONFIDENTIAL)**

No Change in Marital Status _____ Divorce _____ Separation _____

Non-Custodial Parent May _____ May Not _____ sign child out of school.

In case of an accident or serious illness, I request the school to contact me. It will be the parent/guardian responsibility to come to the school for the child. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary for the welfare of my child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

FAMILY DOCTOR _____ Phone_____

I have carefully read and understand the attachment explaining the school's EARLY ALERT PROGRAM. By affixing my signature below & by providing the appropriate information, I agree to be bound by the terms of the EMERGENCY CARE AND EARLY ALERT procedures.

_____ _____

Date Parent's Signature

(over)

AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION IN SCHOOL FOR ACUTE ILLNESSES

Our School Medical Inspector, Ronald M. Frank, MD has authorized the administration of the following medications by the School Nurse in the School Health Office. However, parental/guardian permission is required before a student can receive any of the listed medications. If you would like your child to be able to receive any of the listed medications in school if needed, please complete the following and return it to the Health Office. Students will receive only ONE DOSE during the school day.

The following section is to be completed by the PARENT/GUARDIAN:

_____ _____

Student's Name Date

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C.: 6A: 16-2 3. I understand the ultimate responsibility for administration of the medication is mine and I am fully aware that the duties of the School Nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

I authorize the administration of (check all that apply):

☐ Acetaminophen dosed according to weight and product label.
☐ Ibuprofen dosed according to weight and product label.
☐ TUMS® dosed according to product label.

Signature (parent/guardian):_____

Printed Name:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____

RECOMMENDATIONS ARE EFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY.

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

_____.

*Restrictions:(please describe)_____

_____

_____

*Must have physicians orders.

Dental Exam:_____ _____

Date Braces

Eye Exam:_____ _____

Date Glasses/Contacts