EMERGENCY VERIFICATION FORM

Please sign as indicated. Also, please fill in any missing information and make corrections where necessary.

Current School:	Grade:	Homeroom:

Student's Name:	DOB:	Sex:

Legal Residence:	Mailing Address if different than residence
	Court Orders/Legal Restrictions

Emergency numbers will only be used in the event that we cannot reach you at the other numbers listed.
Please check one number to be used for the attendance auto-dialer.

Guardian 1:		Relationship:	
☐ Home:	☐ Home Cell:	☐ Work:	☐ Work Cell:
Guardian 2:		Relationship:	
Home:	Home Cell:	Work:	Work Cell:
Emergency 1:		Relationship:	Allowed to pickup: ☐
Home:	Home Cell:	Work:	Work Cell:
Emergency 2:		Relationship:	Allowed to pickup: ☐
Home:	Home Cell:	Work:	Work Cell:
Emergency 3:		Relationship:	Allowed to pickup: ☐
Home:	Home Cell:	Work:	Work Cell:

Health care provider information (for emergency treatment when we are unable to contact you):

Contact Type	Contact Name	Contact Number
Hospital		
Doctor		
Dentist		

Does your child have health insurance (Y/N):
Insurance company name:

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 NJ FamilyCare Program to contact me about health insurance.

Signature: ______________________ Date: __________

Does your child have a computer with Internet access at home? Yes☐ No ☐

Brothers and Sisters attending Pemberton Township Schools

Student Name	School	Grade

For School Use Only: Student ID:	Date filed:
Date Updated in Database:	Initials:

Pemberton Township School District Student Medical History

Since the health of a child can affect his/her ability to learn in school, please assist our school personnel in providing the following information:

Student Name: ____ Birthdate: ___________________ M___ F___

Current Health Information - Please answer all the following questions by circling Yes (Y) or No (N). If Yes (Y) is circled, please provide additional information in the space provided.

Y	N	Is your child now under the care of a physician for a medical or surgical problem?
Y	N	Does your child have any physical limitations or restrictions?

Has your child experienced any of the following? Please make sure to circle if it is an allergy *or* a sensitivity.

Circle One			**If yes, give specific details, dates and medication**
Y	N	Asthma	
Y	N	ADD *or* ADHD **(circle one)**	
Y	N	Medication **allergy** *or* **sensitivity (circle one)**	
Y	N	Bee sting **allergy** *or* **sensitivity (circle one)**	
Y	N	Food **allergy** *or* **sensitivity (circle one)**	
Y	N	Seasonal or environmental allergies - **specify ➔**	
Y	N	Diabetes	
Y	N	Frequent ear infections	
Y	N	Frequent bladder or kidney infections	
Y	N	Frequent nosebleeds	
Y	N	Seizure disorder	
Y	N	Headaches	
Y	N	High blood pressure	
Y	N	Heart conditions	
Y	N	Concussion/head injury requiring medical treatment	
Y	N	History of fainting with exercise	
Y	N	Operations (not stitches for lacerations)	
Y	N	Fractures (broken bones) or dislocations	
Y	N	Speech problems	
Y	N	Mental health concerns	
Y	N	Hearing concerns-hearing aid/implant/ear tubes	
Y	N	Vision concerns-wears glasses and/or contacts	
Y	N	Any chronic/serious illness not mentioned above	
Y	N	***Medication taken at home or in school***	

****If medication is needed in school it MUST be brought to the health office in the original container with a physician's order. The child's parent/guardian is required to complete the Student Medication Permission Form. Medication orders must be renewed EVERY school year or participation in ANY activities (after school, field trips, etc.) will be denied.***

Y	N	****Tylenol/acetaminophen or Motrin/Ibuprofen given by the nurse every 4-6 hours**

**Our school physician has written orders for the nurse to give the recommended OTC manufacturer's dosage of Tylenol/acetaminophen or Motrin/ibuprofen every 4-6 hours as needed for pain/fever with your permission as per nurse's assessment. By signing this form you hereby release the Pemberton Township BOE and all school district personnel from liability.

I understand that relevant information regarding my child's health may be shared with the appropriate school personnel and other healthcare providers as necessary. In case of serious illness or injury, I request that the school contact me or the physician named. If neither is available, I give the school permission to make all necessary arrangements to obtain emergency care for my child including taking my child to the hospital. I will also call the school when my child is absent.

Signature: ____ Date: ____

Home Phone: _____________________________________ Cell Phone: ____________________________________

Doctor's Name: ___________________________________ Dr.'s Phone: ___________________________________