WOOD-RIDGE PUBLIC SCHOOLS 2023-2024 EMERGENCY/HEALTH SERVICES

STUDENT'S NAME _____ GRADE _____

ADDRESS _____

_____

HOME PHONE NUMBER _____

Dear Parent/Guardian:

Your child's well being is our concern; we need the information asked in the questionnaire below so we can take care of him/her in case of illness, accident or other emergency. You may add any pertinent information on the reverse side of this page.

Father's/Stepfather's Name _____

Business phone (please include area code) _____

Beeper/Cell # _____

Mother's/Stepmother's Name _____

Business phone (please include area code) _____

Beeper/Cell # _____

Child is living with _____

Are there any legal custody regulations regarding your child?

Yes _____ **No**_____

[If yes, court documents must support this in order for the school to enforce regulations]

In the event the school cannot reach either parent at home or at work, please list two relatives or friends who would have the authority to advise us regarding your child's welfare. The persons you list must be available to pick up your child during school hours. Please list below the two names that you wish the school to call in case the child is sick, injured, or if there is an emergency school closing. According to Board Policy #8220, a parent of a **High School** student may authorize the self-release of the student in the case of an emergency early dismissal from school. Please indicate below your decision regarding this procedure.

(JR/SR HIGH SCHOOL STUDENTS ONLY) I authorize the self-release of my child in case of an emergency early dismissal from school.

_____My child cannot be dismissed from school for an emergency early dismissal unless I, or a temporary caretaker, am reached by telephone. Phone numbers at which someone can be reached **during the school day** are:

NAME _____

RELATIONSHIP _____

ADDRESS _____

_____

PHONE _____

NAME _____

RELATIONSHIP _____

ADDRESS _____

_____

PHONE _____

Parent/Guardian Signature_____

Date _____

**** P L E A S E C O M P L E T E O T H E R S I D E ****

MEDICAL ALERT

Each year, we will update the medical alert and special consideration list. This is a list of students who have special medical problems or need special consideration. If your child has a condition, please fill out the form and return it during the FIRST WEEK OF SCHOOL. Please write "NONE" in the spaces below if no issues exist. This information will be shared with faculty on a need to know basis in order to provide the best care for your child.

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Student's Name & Grade_____

Date of Birth _____

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 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.
Written consent required pursuant to 20 U.S.C. & 123g (b)(1) AND 34 C.F.R. 99.30(b).

Signature:_____
Printed name:_____
Date:_____

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

_____

Dental Exam _____ _____
Date of exam braces

Eye Exam _____ _____
Date of exam contacts /glasses

Allergy _____ _____
Kind Medications

Allergic Reaction _____

Immunizations/Tetanus _____ _____
Date Type

Restrictions: _____

Family Physician _____

Phone _____

Dentist _____

Phone _____

All immunizations must be signed by a physician or health department and placed on file in the Nurse's Office. State law requires that pupils in grades 9 through 12 receive the Hepatitis B vaccination series. Upon completion of the series, the school requires documented proof signed by a licensed physician listing the month, day and year of each immunization. If this requirement has not been met, students will be excluded from school.

If your child is a new student entering the school, a new transfer or is participating in athletics, please check one of the following:

☐ I hereby authorize the school physician to give my child his physical screening.

☐ I will take my child to our physician for a physical examination during the next month. Please send the proper forms.

State law requires that pupils starting at age ten or grade 5 have a scoliosis screening every two years. Please check one of the following:

☐ I hereby authorize the school nurse to give my child a scoliosis exam.

☐ I will take my child to our physician for a scoliosis exam during the next month. Please send me the proper form.

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 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.

Parent/Guardian Signature _____

Date:_____