# 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):<br>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.<br><br>Signature: ______________________ Date: __________ |
|---|---|

| Does your child have a computer with Internet access at home? Yes☐ No ☐ | Military Affiliation? Active ☐ Reserves ☐ None ☐ |
|---|---|

**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 or No**

| | | | |
|---|---|---|---|
| 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 ever experienced any of the following?** | | | |
| *Circle one* | | | *If yes, indicate date, details, 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 | Diabetes | |
| Y | N | Frequent ear infections | |
| Y | N | Frequent bladder or kidney infections | |
| Y | N | Frequent nose bleeds | |
| 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 | Need for hearing aide/implant/ear tubes/hearing concerns | |
| Y | N | Wears glasses and/or contact lenses/vision concerns | |
| Y | N | Any chronic/serious illness not mentioned above | |
| **Y** | **N** | ***Medication 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 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 health care 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: ______________________________