Westfield Public Schools
Westfield, New Jersey 07090
STUDENT EMERGENCY MEDICAL FORM (2018-19)

STUDENT'S NAME:	**STUDENT'S BIRTHDAY :** **STUDENT'S STATE ID:**	**GRADE:** **HOME PHONE NO:**
LEGAL RESIDENCE:	**CITY:**	**ZIP:**

Parent/Guardian Information:
Parents in same household as student: Guardian 1 is mother, Guardian 2 is father.
Parents in separate households: Guardian 1 is custodial parent, Guardian 3 is non-custodial parent.
(Guardian 1 must have the same Westfield home address as student)

GUARDIAN 1 (Relationship:)	**GUARDIAN 2** (Relationship:)	**GUARDIAN 3** (Relationship:)
NAME:	**NAME:**	**NAME:**
HOME PHONE NO:	**HOME PHONE NO:**	**HOME PHONE NO:**
WORK PHONE NO:	**WORK PHONE NO:**	**WORK PHONE NO:**
CELL PHONE NO:	**CELL PHONE NO:**	**CELL PHONE NO:**
E-MAIL:	**E-MAIL:**	**E-MAIL:**

HOME ADDRESS (non-custodial parent) :	**CITY:**	**ZIP:**

IN MY/OUR ABSENCE, THE FOLLOWING (RELATIVE, NEIGHBOR, FRIEND OR CARETAKER) IS AUTHORIZED TO ACT FOR ME/US IN BEHALF OF MY/OUR CHILD. (*PLEASE BE SURE THE FOLLOWING PEOPLE HAVE CONSENTED TO ACT IN YOUR BEHALF)*

NAME:	**ADDRESS:**	**PHONE NO:**
NAME:	**ADDRESS:**	**PHONE NO:**
NAME:	**ADDRESS:**	**PHONE NO:**

IF MY/OUR CHILD REQUIRES IMMEDIATE MEDICAL ATTENTION BECAUSE OF ILLNESS OR AN ACCIDENT AND I CANNOT BE REACHED BY TELEPHONE, I AUTHORIZE THE SCHOOL TO SUMMON MEDICAL ASSISTANCE AT MY EXPENSE. PLEASE CALL:

PHYSICIAN'S NAME:	**PHONE NO:**
DENTIST'S NAME:	**PHONE NO:**
HOSPITAL INFORMATION:	**PHONE NO:**

Does child have Health Insurance?
YES_____ If YES, name of insurance company _____
NO _____ If 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 Family Care Program to contact me about health insurance.

SIGNATURE: _____ **PRINT NAME:** _____ **DATE:** _____

Written consent required pursuant to 20 U.S.C. δ 1232g (b)(1) and 34 C.F.R. 99.30 (b).

Dental Exam _____ _____ **Eye Exam** _____ _____ _____
Date **Braces(Y/N)** **Date** **Contacts(Y/N)** **Glasses(Y/N)**

Allergy _____ _____
Kind **Medications**

Allergic Reaction _____ _____
Date **Medications**

Tetanus Immunization _____ _____
Date **Vaccine type (Td or Tdap)**

Restrictions _____
Type

LIST ANY MEDICAL/SURGICAL CARE YOUR CHILD HAS RECEIVED DURING THE PAST YEAR: _____

_____

I GIVE CONSENT TO THE HEALTH SERVICES DEPARTMENT TO:	**Yes**	**No**
-Share my child's health information including medications with my child's teachers and other appropriate school personnel		
-Screen for Scoliosis (GRADES 5,7,9,11)		

Please list other children attending Westfield Public Schools (Name, School) _____

_____

PARENT/GUARDIAN AUTHORIZATION: MUST BE SIGNED AND RETURNED TO YOUR CHILD'S SCHOOL

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 JUDGEMENT, 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.

_____
SIGNATURE PARENT/GUARDIAN **DATE**