

## Academy of Saint Elizabeth Medical Record

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

City, Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Person to be contacted in the case of an emergency, if neither parent can be reached:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number(s) \_\_\_\_\_

Does student have Health Insurance?

Yes \_\_\_\_\_ If yes, name the insurance company \_\_\_\_\_

No \_\_\_\_\_ 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](http://www.njfamilycare.org) to apply online.

I grant permission for the nurse to share relevant health information with the Academy of St. Elizabeth faculty and staff to protect my daughter's health and safety.

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date