STUDENT _____ _____ _____ _____ _____

Last First Birth Date Gr. School Year

ADDRESS _____ _____

Street City Zip Home Phone

Father/Guardian's Name: _____ **Mother/Guardian's Name:** _____

Address (if different) _____ **Address (if different)** _____

Phone (if different) _____ **Phone (if different)** _____

Employer: _____ **Employer:** _____

Work Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Cell Phone:** _____

Email Address: _____ **Email Address:** _____

Paste recent photo here

Custody of Child:
(circle one) ***Both Parents*** ***Mother Only*** ***Father Only*** ***Other*** _____

Someone who will assume temporary care of your child if you can't be reached during school hours:

1. **Name** _____ **Relation** _____ **Phone** _____
2. **Name** _____ **Relation** _____ **Phone** _____
3. **Name** _____ **Relation** _____ **Phone** _____

Does this child have any health insurance including NJ Family Care/ Medicaid. Medicare, private or other?

Yes_____ If yes, name of insurance company

_____

No _____ NJ Family Care provides free or loss 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.

Signature: _____

Printed Name: _____

Date _____

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

Local Physician's Name _____ **Phone** _____

HEALTH HISTORY– HAS YOUR CHILD EVER HAD OR HAVE NOW ANY OF THE FOLLOWING:

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
Concussion or severe head injury				High Blood Pressure				Excessive worry or anxiety			
Seizure disorder				Heart Condition				Depression			
Frequent or severe headache				Asthma				Ulcer			
Dizziness or fainting spells				Contact with tuberculosis				Severe or chronic abdominal pain			
Hearing loss				Attention deficit disorder				Intestinal problems			
Frequent or painful urination				Tumor, growth or cancer				Eye problems			
Scoliosis in family				Diabetes or sugar in urine				Wears glasses/contacts			
Severe menstrual cramps				Serious skin condition				Frequent ear infections			

Explain any of the above conditions:

_____

List current medications/dose/reason for taking medication:

_____

Allergies

List allergies to bees, medication, foods, etc: _____

Describe reaction/required treatment: _____

Check here if your child carries: Epipen_____ Inhaler_____ (Must provide doctor's note)

I authorize the school to proceed with emergency arrangements if the designated individuals are unavailable. This information may be shared with school staff on "educational need to know" basis, and may be listed on my child's medical profile.

Signature of Parent or Guardian _____ **Date** _____