

HILLSIDE PUBLIC SCHOOLS

A.P. Morris Early Childhood Center

ID # _____
Last Name _____ First _____ Initial _____ Date of Birth (MM/DD/YYYY) _____
Address _____
City _____ Zip _____ School _____
Home Phone (____) _____ Grade _____
Teacher/H.R. _____

To Parent/Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for EMERGENCY CALLS.

Parent/Guardian 1 Name _____ Relationship _____
Phone Numbers: Home (____) _____ Cell (____) _____ Work (____) _____ Email _____
Parent/Guardian 2 Name _____ Relationship _____
Phone Numbers: Home (____) _____ Cell (____) _____ Work (____) _____ Email _____

List two neighbors or nearby relatives who will assume temporary care of your child(ren) if you cannot be reached:

Neighbor/Relative 1 Name _____ Address _____
Phone Numbers: Home (____) _____ Cell (____) _____ Work (____) _____ Email _____
Neighbor/Relative 2 Name _____ Address _____
Phone Numbers: Home (____) _____ Cell (____) _____ Work (____) _____ Email _____

Please list other children attending New Jersey Public Schools (Name, Grade, School)

Please check this box if there has been a name change of parent/guardian, address or telephone number.

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?
 NO My child **does not** have health insurance. 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. § 1232g(b)(1) and 34 C.F.R. 99.30(b).

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

YES My child has health insurance.

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

Dental Exam	_____	Date	_____	Braces	_____
Eye Exam	_____	Date	_____	Glasses /Contacts	_____
Allergy	_____	Kind	_____	Medications	_____
Allergic Reaction	_____	Date	_____	Medications	_____
Immunizations/Tetanus	_____	Date	_____	Type	_____
Restrictions	_____	Type	_____	Phone	_____
Doctor	_____	Phone	_____	Phone	_____
Dentist	_____	Phone	_____	Phone	_____
Hospital	_____	Hospital Name/Address	_____	Phone	_____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) 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/guardians 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.

Signature of Parent(s) / Guardian(s) _____ Date _____