

SADDLE BROOK SCHOOL DISTRICT EMERGENCY CONTACT FORM

Please check if this is a NEW student.
 Please check if this information is DIFFERENT from last year.

1. STUDENT INFORMATION

Name: _____
Address: _____
Home Telephone: _____ Birth Date: _____
Grade: _____ Teacher _____ School Year _____

2. PARENT/GUARDIAN INFORMATION:

Father's/Guardian's Name _____ Home Tel. # _____
Work Tel. # with Ext. _____ Cell # _____
Email Address _____

Mother's/Guardian's Name _____ Home Tel. # _____
Work Tel. # with Ext. _____ Cell # _____
Email Address _____

Parents or guardians listed above have permission to pick up the child, unless otherwise indicated.

Notify the school principal immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the principal with a copy of the order.

3. CONTACTS DESIGNATED TO PICK UP MY CHILD IN AN EMERGENCY:

A. Contact _____ Relationship to Child _____
Home Tel. # _____ Work Tel. # with Ext. _____
Cell # _____

B. Contact _____ Relationship to Child _____
Home Tel. # _____ Work Tel. # with Ext. _____
Cell # _____

C. Contact _____ Relationship to Child _____
Home Tel. # _____ Work Tel. # with Ext. _____
Cell # _____

4. MEDICAL INFORMATION:

Allergies to Food	Allergies to Medications	Any other Allergies

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

Doctor's Name: _____ Tel. # _____
Hospital Preference: _____
Dentist's Name: _____ Tel. # _____

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5. SIBLING INFORMATION:

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

_____	_____
_____	_____
_____	_____
_____	_____

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

Yes _____ If Yes, name and number of insurance company _____

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: _____ Printed Name: _____ Date: _____

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

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 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