CLIFTON PUBLIC SCHOOLS
EMERGENCY REFERENCE SHEET

Name of Student _____ Teacher/Homeroom _____ Grade _____
Last Name First Name

Date of Birth _____ ID# _____ School Year 20____-20____

Address _____ Home Phone _____

Mother's/ Guardian's Name _____ Work Phone _____ Cell Phone _____

Father's / Guardian's Name _____ Work Phone _____ Cell Phone _____

Do mother and father (Guardians) live together? Yes_____No_____ Student lives with_____

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

Name _____ Name _____

Relationship _____ Relationship _____

Home Phone _____ Home Phone _____

Work/Cell Phone _____ Work/Cell Phone _____

Please list other children in family (including those not yet in school)

Name _____ Date of Birth _____ School _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Does child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other? (Please check one box)

☐ **NO,** my child **does not** have health insurance. You may release my name and address to 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 call 800-701-0710 or visit www.njfamilycare.org to apply online.

☐ YES**,** my child has health insurance. Name of Insurance Provider: _____

List any medical/surgical care your child received during the past year: List eye exams and dental exams. Also list any medication your child takes at home.

_____

Allergy _____ Immunizations _____

Doctor's Name _____ Telephone _____

Dentist's Name _____ Telephone _____

Hospital Preference _____

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 my 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 my child.
I will not hold the school district financially responsible for the emergency care and/ or transportation for my child.

I hereby give permission to the school nurse to share any medical information about my child to other school staff on a need to know basis.

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

PLEASE CONTACT THE SCHOOL IF YOUR CHILD IS ABSENT.

☐Please check this box if there has been a name change of parent/guardian, address or telephone change since last school year.