

# CLIFTON PUBLIC SCHOOLS

ADMINISTRATION OFFICES

P.O. BOX 2209

745 CLIFTON AVENUE

CLIFTON, NEW JERSEY 07015-2209

2010-2011

Dear Parent,

New Jersey has made a commitment to provide affordable health insurance for children in the state.

Your child's school is now required to report on the health insurance status of all of their students; therefore, you will be asked by your child's school to provide the current health insurance status of your child.

We would also like to take this opportunity to let you know that the NJ FamilyCare program offers free or low-cost health insurance for children 18 or younger and certain low-income parents. With your permission, we will take steps to have an application sent to you or if you think your family may be eligible for the NJ FamilyCare program, you can call 1-800-701-0710 or visit the website at [www.njfamilycare.org](http://www.njfamilycare.org) where you can apply online.

Parents or guardians who earn too much to qualify for NJ FamilyCare can purchase health insurance for their children at reasonable rates through another program called NJ FamilyCare Advantage, which is administered by Horizon NJ Health. For more information about this program, please call NJ Advantage at 1-800-637-2997 or visit [www.horizonNJhealth.com](http://www.horizonNJhealth.com).

Therefore the attached form needs to be completed and returned to school by November 19, 2010. **Please sign the card in the insurance section only if you wish to receive information about the NJ FamilyCare program.**

Your signature is required in the last section of the card.

Healthy children make better students!

Sincerely,

Mr. Richard Tardalo

Superintendent of Schools

**EMERGENCY REFERENCE SHEET**

From: School Nurse

Name of Student \_\_\_\_\_ Teacher/Homeroom \_\_\_\_\_ Grade \_\_\_\_\_  
Last Name First Name Date of Birth \_\_\_\_\_ ID# \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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 \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

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

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ School \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Does child have Health Insurance?

Yes \_\_\_\_\_ If Yes, name of 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.

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

**Signature of Parent or Guardian** \_\_\_\_\_

**Printed Name of Parent or Guardian** \_\_\_\_\_

**Date:** \_\_\_\_\_ (If you do not wish your information released do not sign above)

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

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

\_\_\_\_\_

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.