**Butler Public Schools Emergency Information Card**

Grade ___ Room ___ Teacher_____ Age___ Birth date_____
Month Day Year

Pupil's Name_____
(Last) (First) (Middle)

Address _____Home Tel.# _____

Mother's Name _____ Father's Name _____
Cell # _____ Cell # _____
Business Address _____ Business Address _____
Business Phone _____ Business Phone _____
(If Mother does not work, please write "Home" next to business address)

Person who will assume temporary care of your child if you can not be reached:
Name _____ Name_____
Address _____ Address_____
Tel. # _____ Tel. # _____
Relationship _____ Relationship _____

**Siblings_____ Birth date _____**
_____ _____
_____ _____

Student is living with _____/_____/_____/_____/_____
Mother Father Step-Mother Step-Father Guardian

Student May be released to anyone listed on this card ___/___
Yes No

Student **MAY NOT** be released to: _____

Family Physician _____ Physician's Tel. # _____

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 physician 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 judgement, 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_____**

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

1. Allergies? To what? Any medication needed?

2. Diabetes? Medication?

3. Epilepsy? Last Seizure?

4. Hearing, Vision, Physical or Emotional Problems?

5. Name and dosage of Medications taken on a daily basis? For What?

**Board Policy:** The School Nurse is unable to give any medication, including Tylenol and other over-the-counter medications without a Doctor's order.

Does your child have Health Insurance? Yes ___ No ___
If yes, name of insurance company _____
NJ FamilyCare provides free or low cost health insurance for uninsured children and 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. 1232g (b)(1) and 34 C.F.R. 99.30 (b)**