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)