Union County Educational Services Commission
Student Emergency/Information Form
2023 - 2024 School Year

Student Information

Last Name ____ First Name ____ Middle Initial ____ Date of Birth ____

Street Address ____ Town or City ____ Zip Code ____

Home phone ____ Cell phone ____ Email address ____

Mother's Name/Legal Guardian

Last Name ____ First Name ____ Home phone ____ Cell phone ____

Street Address ____ Town or City ____ Zip Code ____

Employer ____ Employer's Address ____ Work Phone ____

Father's Name/Legal Guardian

Last Name ____ First Name ____ Home phone ____ Cell phone ____

Street Address ____ Town or City ____ Zip Code ____

Employer ____ Employer's Address ____ Work Phone ____

If I cannot be reached, you have my permission to contact one of the following people who will care for my child until I'm available. Please DO NOT use the same phone numbers listed above.

1. Name ____ Relationship ____
   Home Phone ____ Cell Phone ____
2. Name ____ Relationship ____
   Home Phone ____ Cell Phone ____
3. Name ____ Relationship ____
   Home Phone ____ Cell Phone ____

Parent/Guardian Signature ____ **Date** ____

Medical Information

Student's Last Name	First Name	Middle Initial	Date of Birth

Student's Doctor ______________________ Date of last physical ____________

Address ______________________ Phone ____________

In case of emergency, may we contact your child's doctor? ☐ Yes ☐ No

Please list allergies, including food and drug allergies:

____

____

____

Is your child subject to seizures? ☐ Yes ☐ No

Please list dates, place(s), and reason(s) for any recent hospitalizations.

____

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____

Is your child medically excused from physical education (gym)? ☐ Yes ☐ No

Please note: State Law requires a doctor's note in order for a student to be excused from physical education classes.

I hereby give the school nurse permission to perform a scoliosis screening. ☐ Yes ☐ No

If you DO NOT give permission, a doctor's note must be sent to the school nurse with the screening results.

Please list any medications your child takes at home or in school.

Medication ____________ Dosage ____________ Frequency ____________

Medication ____________ Dosage ____________ Frequency ____________

Medication ____________ Dosage ____________ Frequency ____________

Please list any additional medical/health concerns.

____

Medical Insurance Carrier ______________________

Medicaid Number *(if applicable)* ______________________

Do you give permission to share student's medical information with his/her teacher and appropriate staff?

☐ Yes ☐ No

If your child does not have health insurance including NJ FamilyCare/Medicaid, Medicare, private or other, please contact NJ FamilyCare which provides free or low cost health insurance for uninsured children and certain low income parents. For more information, please visit www.njfamilycare.org to apply online or call (800) 701-0710.

If my child requires immediate medical attention because of illness or accident and I cannot be reached by telephone, I hereby authorize Union County Educational Services Commission to secure appropriate medical assistance at my expense.

Parent/Guardian Signature: ______________________ **Date** ____________