

Emergency Contacts

The Lester C. Noecker will be adding this important contact information into our database. Please complete and return as soon as possible. Thank you.

Part One	
Student Name	
Student Address	
Student Date of Birth	
Student Grade/Homeroom	
Parent/Guardian 1	
Parent/Guardian 1 Name	
Parent/Guardian 1 Home Phone	
Parent/Guardian 1 Cell Phone	
Parent/Guardian 1 Work Phone	
Parent/Guardian 1 E-mail	
Parent/Guardian 2	
Parent/Guardian 2 Name	
Parent/Guardian 2 Home Phone	
Parent/Guardian 2 Cell Phone	
Parent/Guardian 2 Work Phone	
Parent/Guardian 2 E-mail	
<i>Please asterisk above which number to use for primary contact</i>	
If we cannot reach either parent/guardian listed above, list below two people that you will allow us to contact and who you allow to assume temporary care of your child.	
Medical Emergency Contact 1	
Emergency Contact 1 Name	
Emergency Contact 1 Home Phone	
Emergency Contact 1 Cell Phone	
Emergency Contact 1 Work Phone	
Emergency Contact 1 E-mail	
Medical Emergency Contact 2	
Emergency Contact 2 Name	
Emergency Contact 2 Home Phone	
Emergency Contact 2 Cell Phone	
Emergency Contact 2 Work Phone	
Emergency Contact 2 E-mail	

Annual Medical Information

The Lester C. Noecker will be adding this important medical information into our database. Please complete and return as soon as possible. Thank you.

Child's Name: _____

School Year: _____

Does your child have Health Insurance? _____

If yes, what is the name of your insurance company? _____

No

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

Printed Name: _____

Signature: _____

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

Date: _____

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

Dental Exam Date: _____

Braces: _____

Eye Exam Date: _____

Contacts: _____ Glasses: _____

Allergy (kind): _____

Medications: _____

Allergic Reaction Date: _____

Medications: _____

Immunizations/Tetanus Date: _____

Type: _____

Restrictions Type: _____

Doctor Name: _____

Doctor Telephone: _____

Dentist Name: _____

Dentist Telephone: _____

Hospital Name: _____

Hospital Telephone: _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named in this form and do authorize the named physicians 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 in this form, 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 aforesaid child. I will not hold the district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent/Guardian: _____

Print Parent/Guardian Name: _____

Date: _____