International Charter School of Trenton — EMERGENCY ILLNESS FORM

June 2014-15

Student Last Name______________________ **First**____________ **Initial**_____ **Date of Birth (MM/DD/YYYY)**__________________

Address______________________________________ **Grade**______________________________________

City______________________ **Zip** ____________ **Home Phone**__________________________________

To Parent/Guradian: *To serve your child in case of accident or sudden illness, it is necessary that you give the following information for EMERGENCY CALLS.*

Mother: Name:_________________________ **Address:**____

Phone Numbers: Home (   )______________**Cell: (   )**______________**Work (   )** ______________**Email**__________________

Father: Name _________________________ **Address:**____

Phone Numbers: Home (____)______________**Cell (____)**______________**Work (____)**______________ **Email**__________________

List two neighbors or nearby relatives who will assume temporary care of your child(ren) if you cannot be reached:

Neighbor/Relative 1 Name______________________ **Address**______________________ **Relationship**______________

Phone Numbers: Home (___)______________**Cell (____)** ______________ **Work (____)** ______________ **Email**__________________

Neighbor/Relative 2 Name ______________________**Address**______________________**Relationship**______________

Phone Numbers: Home (___)______________ **Cell (___)**______________ **Work (___)**______________ **Email**__________________

Please list other children attending Trenton Public Schools (Name, Grade,School)

____ ____

____ ____

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

Student Last Name______________________ **First**______________________ **(SID#**______________________**For Office Use Only)**

******PLEASE FILL OUT BOTH SIDES —-> SIGN & DATE —> POR FAVOR LLENE AMBOS LADOS —-> FIRMA & FECHA *** ———>***

Does this child have any health insurance including NJ Family Care/Medicaid, private or other?

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 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).

LIST ANY HEALTH CONDITIONS:____

Date of Last Medical Exam:___________________________________ **Date of Last Dental Exam:**____

Medications currently prescribed:____

List any Restrictions:____ _ __

Allergies to Medications____

Allergies to Food____

Other Allergies____ ___

Doctor____ **Phone**________________________________

Dentist____ **Phone**________________________________

Hospital Name/Address____ **Phone**___________________________

I, the undersigned, do hereby authorize officials of The International Charter School to contact directly the person(s) 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 said child. In the event that physicians, other persons named on this card, or parents/guardians 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 school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent(s)/Guardian(s)____ **Date**________________________________

******PLEASE FILL OUT BOTH SIDES —-> SIGN & DATE —> POR FAVOR LLENE AMBOS LADOS —-> FIRMA & FECHA *** ———>***