West Orange Public Schools
Emergency Information Form

Student Information			
Name	**Birth Date**	**Gender**	**School Year**
Address	**School**	**Grade**	**Teacher**

Parent/Guardian Information		
Name	**Email**	**Cell Phone**
Relationship: ☐Mother ☐ Father ☐Guardian	**Home Phone**	**Work Phone**
Name	**Email**	**Cell Phone**
Relationship: ☐Mother ☐ Father ☐Guardian	**Home Phone**	**Work Phone**

Emergency Contact Information		
Name	**Relationship**	**Cell Phone**
	Home Phone	**Work Phone**
Name	**Relationship**	**Cell Phone**
	Home Phone	**Work Phone**

Siblings Attending West Orange Public Schools		
Name	**School**	**Grade**

Other Student Information		
Doctor Name	**Doctor Phone**	**Date of Last Physical Exam**

Family Medical History
Conditions/Diseases parent(s) or sibiling(s) had or currently have (please check all that apply) **☐Significant allergy ☐Rheumatic fever ☐Heart disease ☐Diabetes ☐Tuberculosis ☐Convulsive disorder ☐Cancer ☐Mental illness ☐Other**
If any box is checked, Explain:

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

☐ **YES** My child has health insurance.

☐ **NO** My child does not have 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).

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

I will provide for my student's school nurse to hold his/her medication/treatment should he/she ever require medication/treatment as described. ☐ YES ☐ NO

I understand that any changes stated on this card regarding my child's health history needs to be communicated to the school nurse/principal. I also give permission for the release of information for confidential use in meeting my child's health and educational needs in school. I the undersigned, do herby authorize officials of West Orange Public Schools to contact directly the person(s) named on this card and o 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 the contact 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: _____**Printed name:** _____**Date:** _____

Health Conditions	Yes	No	Explanation if Yes
Medication Allergies			**List:** | **Reaction:**
Food Allergies			**Food(s):** ☐peanut ☐dairy ☐eggs ☐celiac/other_____ **Reaction:** **Rate severity:** ☐mild ☐moderate ☐life-threatening | **Requires EpiPen?** ☐yes ☐no
Allergy to Bees Stings			**Rate the reaction:** ☐mild ☐moderate ☐life-threatening **Does your child require an EpiPen?** ☐yes ☐no
Allergies (other)			**List:**
Asthma/Reactive Airway			**Rate severity:** ☐mild ☐moderate ☐life-threatening **Asthma medication(s) taken at home:** **Medication(s) required at school:**
Diabetes			☐**Type 1** (Insulin Dependent) ☐**Type 2** | **Diabetes medication(s):**
Seizure Disorder			**Type of seizure:** **Medication(s):** **Date of last seizure:**
ADD/ADHD			**Treatment/Medication(s):**
Neurological Disorder			**Specify:**
History of concussion/Head injury			**How many?** | **Date of last episode:**
Chickenpox			**Date:**
Heart Condition			**Specify:**
Blood Disorder/Tendency to bleed easily			**Specify:** **Treatment:** **Date of last nose bleed:**
Cancer			**Specify:** | **Treatment:**
Bowel/Bladder Issues			**Specify:**
Migraine Headaches			**Triggers:** | **Treatment:**
Bone/Muscle Problems			**Specify:** | **Activity Restrictions:**
Breath Holding/Temper Tantrums			**Date of most recent occurrence:**
Mental Health/Behavioral Issues			**Specify:** | **Treatment/Medication(s):**
Wears Glasses/Contacts			☐**Glasses** ☐**Contacts** | ☐**For distance** ☐**For reading**
Hearing Loss			☐**Right ear** ☐**Left ear** ☐**Hearing Aid(s)**
Frequent Ear Infections			**Date of most recent occurrence:**
Trouble with Speech			**Describe:**
Other Serious Illness/Injury			**Specify:** | **Date of Onset:**
Surgery/Hospitalization(s)			**Specify:** | **Date(s):**
Other Conditions/Restrictions			**Specify:**
Meditation taken at Home			**List - if not already listed:**