ECLC of NJ 973-635-1700 **2016-2017 EMERGENCY REFERENCE CARD** **BUS________HR________**

Student ____ Birth date ____

Phone

Street Address____________________ Town/Zip________________________ ___________________________ (H)

Mother/Guardian__________________ Address_________________________ ___________________________ (H)

______________________________ ___________________________ (C)

Work Place______________________ ___________________________ (W)

Father/Guardian___________________ Address_________________________ ___________________________ (H)

______________________________ ___________________________ (C)

Work Place______________________ ___________________________ (W)

E-mail address ____

LOCAL person to be called if parent/guardian not available in case of emergency:

Phone

Name__________________________ Town___________________________ _____________________________(H)

Relationship_____________________ _____________________________(C)

Name__________________________ Town___________________________ _____________________________(H)

Relationship_____________________ _____________________________(C)

Student's Physician_________________________________ Phone ____

Student's Dentist___________________________________ Phone____

Preferred hospital for emergency____

Does student take daily medication?____________________ Medication/Dose____________________________________

Medication/Dose____________________________________

Medication/Dose____________________________________

Does student have emergency medication?_______________ Medication/Dose____________________________________

Does student have allergies?__________________________ Reaction/Treatment_________________________________

Does student have health insurance?

Yes_____________________ Name of insurance provider____

No______________________ NJ Family Care provides free and low-cost medical insurance for uninsured children and certain low-income families. For information call 800-701-0710 or visit www.njfamilycare.org to apply on line.

ECLC of NJ may release my name and address to NJ Family Care to contact me about health insurance- written consent required:

*Print Name*__________________________ *Signature*__________________________ *Date*____________________

I hereby give my permission to the school principal and/or ECLC of NJ staff to obtain emergency medication and treatment if required for my child, and I release ECLC of NJ and its employees from all liability in connection therewith.

Parent/Guardian Signature____ **Date**______________________________

I hereby give permission for my child______________________________________ to go on field trips with his/her class at the ECLC of NJ school during the 2016-2017 school year.

Parent/Guardian Signature____ **Date**______________________________

I hereby give my permission for my child's health information to be disclosed to the appropriate ECLC of NJ employees who have a legitimate health interest in my child.

Parent/Guardian Signature____ **Date**______________________________