

Student \_\_\_\_\_ Birth date \_\_\_\_\_

Street Address \_\_\_\_\_ Town/Zip \_\_\_\_\_ Phone \_\_\_\_\_ (H)

**Check if new address** \_\_\_\_\_

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:**

Name \_\_\_\_\_ Town \_\_\_\_\_ Phone \_\_\_\_\_ (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.nifamilycare.org](http://www.nifamilycare.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 current 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 \_\_\_\_\_

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**AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION ADMINISTRATION  
2022–2023 SCHOOL YEAR**

I authorize the ECLC school nurse to administer the following over-the-counter medication to my child during school hours. These medications are in stock in the health office and are approved by the school physician. **Parent/guardian will be contacted prior to administration of any medication.**

Please **CHECK** the medications that may be administered at school with parent permission:

\_\_\_\_ Acetaminophen (Tylenol) – for headache, pain or fever

\_\_\_\_ Ibuprofen (Motrin/Advil) – for headache, pain or fever

\_\_\_\_ Benadryl – for allergy symptoms

\_\_\_\_ Antibiotic Ointment- apply to skin for first aid/wound care

\_\_\_\_ Hydrocortisone Cream 1%- apply to skin for itch or insect bites

\_\_\_\_ Calamine Lotion- apply to skin for skin rash or insect bites

**All other medications, both prescription and over-the-counter, require a medical order from your student’s physician. Medication forms and the medication administration procedure can be found in the health packet.**

Student Name \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

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