



Does your child have Health Insurance?

Yes \_\_\_\_\_ If Yes, name of insurance company \_\_\_\_\_

No \_\_\_\_\_ NJ Family Care 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](http://www.njfamilycare.org) to apply online.

You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Signature

Print name

Date

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

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

Dental Exam	_____	braces	check one	
	date		<input type="checkbox"/> yes	<input type="checkbox"/> no
Eye Exam	_____	contacts	<input type="checkbox"/> yes	<input type="checkbox"/> no
	date	glasses	<input type="checkbox"/> yes	<input type="checkbox"/> no
Allergy	_____		_____	
	date		medications	
Allergic Reaction	_____		_____	
	date		medications	
Immunizations/Tetanus	_____		_____	
	date		type	
Restrictions	_____		_____	
	type			

Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Dentist \_\_\_\_\_ Telephone \_\_\_\_\_

Hospital \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons 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 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 of said child.

Signature of Parent(s) / Guardian (s)

Date