EMERGENCY CONTACT AND HEALTH INFORMATION

Student's Name:_____ DOB: _____Gender _____ Grade: _____

Home Address: _____Home Phone: _____

Student Lives With: _____Father _____Mother _____Both _____Guardian

Mother's Name _____ Employer _____

Cell Phone _____ Work Phone _____ Email_____

Father's Name _____ Employer _____

Cell Phone _____ Work Phone _____ Email_____

Guardian's Name: _____

Cell Phone _____ Work Phone _____

Email Address _____ Relationship to Child _____

List name and DOB of all children living in the home. Please include grade of those children attending other schools:_____ _____ _____

_____ _____ _____

Our child lives 50% or more of the week in : Avalon _____ Stone Harbor_____ Other (May not be the same as your zip code - i. e. CMCH, Clermont, South Seaville, West Cape May, S. Dennis, etc.)_____

List at least two Local Emergency Contacts available to pick up ill or injured child if parent unavailable: NAME/ RELATIONSHIP TO FAMILY/ PHONE NUMBER:

1. _____

2. _____

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, 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).gp;

Please check if your child has any health concerns:_____

____ ADD/ADHD _____ Asthma ____Bleeding Disorder/Anemia _____ Arthritis

____Concussion ____ Cystic Fibrosis ____Diabetes,Type I or II ____ Cerebral Palsy

____Tourette's Syndrome _____ Spina Bifida ____ Cardiovascular Condition ____ Latex Allergy

___Sickle Cell Disease ____ Glasses/Contacts ____ ***__Other__ Medical Conditions ***__Explain__:____

_____

Student Name: _____

Bee Sting Allergies: _____ Is **EpiPen required?** Yes ___No___

Food Allergies: _____ **Is EpiPen required?** Yes ___No___

Medication Allergies: _____ **Is EpiPen required?** Yes ___No___

PLEASE CHECK (✓) MEDICATIONS THAT CAN BE ADMINISTERED AT THE DISCRETION OF THE SCHOOL NURSE by School Physician Order (the nurse will notify you if needed). Students requiring frequent medications during the day will have to supply their own from home along with order from PCP. *I request the nurse to administer the following as need arises and agree to hold harmless and indemnify the school district, its employees and agents, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medications.*

_____ Tylenol or generic **_____ Advil or generic** **____Tums or generic** **____Benadryl or generic** **____cough drop/ throat lozenge**

*Email communication or notes home for a Health Office visit is routine unless there is an emergency: then a phone call home will be made. (Minor incidents for bandages or bumps/bruises will not necessitate a note.)

***N.J.S.A. 18A:40-12.5 ,P.L.2015, c.13 Permits the school nurse or trained delegate to administer epinephrine via a pre-filled auto-injector mechanism to any student without a known history of Anaphylaxis, when acting in good faith believes the student is having an anaphylactic reaction.

MEDICATIONS administered at home:

_____

IMMUNIZATIONS within the past year: _____ Date given: _____

Student's Doctor: _____ Last physical_____ Phone: _____

Student's Dentist: _____Last visit:_____ Phone: _____

Student's Eye Doctor:_____ Last visit:_____ Phone: _____

SOCIAL/FAMILY CHANGES SINCE LAST HEALTH HISTORY (EXAMPLES: DEATH, DIVORCE, MOVES, ETC.):

_____

REMINDER IT IS RECOMMENDED TO **OBTAIN REGULAR PHYSICAL EXAMINATIONS** BY YOUR HEALTHCARE PROVIDER **AT LEAST ONCE** DURING EACH OF THE CHILD'S DEVELOPMENTAL STAGES: EARLY CHILDHOOD (PRESCHOOL-GRADE 3); PRE-ADOLESCENCE (GRADES 4-6); AND ADOLESCENCE (GR. 7-12). PLEASE PROVIDE THE HEALTH OFFICE WITH REPORTS AS OBTAINED. *For Grade 6 entrance, vaccination boosters are required and at that time an updated Physical paper too.*

THE STATE OF NJ MANDATES ALL CHILDREN TO BE SCREENED YEARLY FOR: HEARING, VISION, HEIGHT, WEIGHT, BLOOD PRESSURE, AND SCOLIOSIS (STARTING AT AGE 10). THESE SCREENINGS ARE COMPLETED CONFIDENTIALLY IN THE HEALTH OFFICE THROUGHOUT THE COURSE OF THE SCHOOL YEAR. THE HEALTH OFFICE WILL NOTIFY OF ANY CONCERNS OR PROBLEMS.

ABSENTEEISM SHOULD BE REPORTED TO THE HEALTH OFFICE VIA PHONE OR EMAIL: bossuyt@avesnj.org or fox@avesnj.org . PLEASE PROVIDE A MEDICAL NOTE FOR ANY ABSENCE OF OVER THREE CONSECUTIVE DAYS.

TEACHERS AND STAFF MEMBERS WILL BE GIVEN HEALTH INFORMATION ON AN AS NEEDED BASIS. THIS IS TO ENSURE YOUR CHILD'S SAFETY DURING THE SCHOOL DAY. IF YOU DO NOT WISH THIS INFORMATION TO BE SHARED WITH STAFF PLEASE PROVIDE WRITTEN NOTIFICATION.

I, the undersigned, do hereby authorize officials of Avalon Stone Harbor Schools to contact directly the persons named on this notice and do authorize the school physician or 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 notice, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, 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.

Student Name: _____

SIGNATURE OF PARENT/GUARDIAN: _____DATE: _____