



218 Boulevard • Mountain Lakes, NJ 07046 • (973) 263-1818 • Fax: (973) 311-8418  
www.theacademyforchildren.org

## Emergency Card

Today's Date: \_\_\_\_\_

Child's Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth (Mo/Day/Year) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**To Parent or Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for emergency calls:**

Name	Address	Telephone
Mother: _____	Home: _____	Home: (____) _____ Cell: (____) _____
	Work: _____	Work: (____) _____ Email: _____
Father: _____	Home: _____	Home: (____) _____ Cell: (____) _____
	Work: _____	Work: (____) _____ Email: _____

List two neighbors or nearby relatives(emergency contact persons) who will assume transport and temporary care of your child if you can not be reached:

Name	Name
Home Address _____	Home Address _____
Work Address _____	Work Address _____
Telephone: Home (____) _____	Telephone: Home(____) _____
Cell(____) _____ Work(____) _____	Cell(____) _____ Work(____) _____
Relationship _____	Relationship _____

Does child have Health Insurance?

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](http://www.njfamilycare.org) to apply online. You may release my name and address to 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).

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

- Dental Exam \_\_\_\_\_ Date \_\_\_\_\_ Braces \_\_\_\_\_
- Eye Exam \_\_\_\_\_ Date \_\_\_\_\_ Contacts \_\_\_\_\_ Glasses \_\_\_\_\_
- Allergy \_\_\_\_\_ Kind \_\_\_\_\_ Medications \_\_\_\_\_
- Allergic Reaction \_\_\_\_\_ Date \_\_\_\_\_ Medications \_\_\_\_\_
- Immunizations/Tetanus \_\_\_\_\_ Date \_\_\_\_\_ Type \_\_\_\_\_
- Restrictions \_\_\_\_\_ Type \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Telephone(\_\_\_\_\_) \_\_\_\_\_

Dentist: \_\_\_\_\_ Telephone(\_\_\_\_\_) \_\_\_\_\_

Hospital: \_\_\_\_\_ Address \_\_\_\_\_ Telephone(\_\_\_\_\_) \_\_\_\_\_

I, the undersigned, do hereby authorize officials of The Academy for Children to contact directly the persons named on this card and do authorize the named physicians to render such treatments as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons 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, including calling an ambulance and/or administering medication prescribed by a physician for my child.

I will not hold The Academy for Children financially responsible for the emergency care and/or transportation for said child.

I understand it is my responsibility to update any changes to emergency persons and/or physician information as they occur.

Signature of Parent(s)/Guardian(s)

Date