SOMERSET COUNTY VOCATIONAL & TECHNICAL SCHOOLS
P.O. Box 6350 • 14 Vogt Drive • Bridgewater, NJ 08807-0350 • (908) 526-8900 • www.scvths.org

HEALTH OFFICE EMERGENCY FORM

Please use PEN & PRINT CLEARLY

Name: _____ Home Phone: _____
Last First M.I.

Home Address: _____
Street or P.O. Box City Zip

Mailing Address (if different): _____
Street or P.O. Box City Zip

City of Birth: _____ State of Birth: _____ Country of Birth: _____

Age: _____ Birth Date: ____/____/_____ Grade: _____ CTE Program: _____ Full Time_____ Share Time____

Please Circle RACE: • White • Black • Hispanic • Asian • American Indian • Native Alaskan • Native Hawaiian • Pacific Islander

Father/Guardian's Name: _____ Contact Phone # Home: _____
Cell: _____

Mother/Guardian's Name: _____ Email: _____
Contact Phone # Home: _____
Cell: _____
Email: _____

Other approved **Emergency Contacts** *(Neighbor, Relative, etc):*

(1) _____ (2) _____
Name / Relationship Phone # Name / Relationship Phone #

(3) _____ (4) _____
Name / Relationship Phone # Name / Relationship Phone #

Doctor's Name: _____ Phone #: _____

Dentist's Name: _____ Phone #: _____

Please list any Medical/Surgical Care your child has received during the past year: _____

Existing Conditions: ( ) Asthma ( ) Diabetes 1 or 2 ( ) Heart Condition ( ) Seizure Disorder ( ) Epi-pen for: _____
( ) IBS ( ) Eating Disorder ( ) Anxiety Attacks
( ) Other – Please Explain: _____
Dental Exam: _____ Eye Exam: _____ Allergies-Kind: _____ Medications: _____
Date / Braces Date / Glasses / Contacts

Immunizations/Tetanus: _____ Allergic Reaction-Date: _____ Restrictions: _____

Additional information to aid us in an Emergency: _____
(Use Other Side If Necessary)

PLEASE NOTE: Parent/Guardian Signature Is Required for BOTH Boxes:

Do you have Medical Insurance? Yes____ No____ If Yes, Company Name: _____

Note: NJ Family Care provides free or reduced health insurance for uninsured children & certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name & address to the NJ Family Care Program to contact me about health insurance.

Parent/Guardian Signature: _____ Printed Name: _____ Date: _____
Written consent required pursuant to 20 u.s.c. & 1232g (b)(1) and 34;C.F.R.

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 or 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.
( ) Please check this box if there has been a name change of a Parent/Guardian or Telephone Number(s).

Parent/Guardian Signature: _____ Printed Name: _____ Date: _____
PLEASE NOTE: Medical information may be shared with school personnel, on a need-to-know basis, when indicated to protect your child's health.