



MEETING THE SPECIAL NEEDS OF CHILDREN

**2018-2019  
EMERGENCY INFORMATION**

Student Name \_\_\_\_\_  
(Please Print) Last First

Address \_\_\_\_\_  
Street City Zip Code

Mother: \_\_\_\_\_ Home Tel. \_\_\_\_\_ Cell \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Work Tel. \_\_\_\_\_

Best Method of Contact: \_\_\_\_\_

Father: \_\_\_\_\_ Home Tel. \_\_\_\_\_ Cell \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Work Tel. \_\_\_\_\_

Best Method of Contact: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

List two emergency contacts who will assume temporary care of your child if you cannot be reached.

1. Name: \_\_\_\_\_ Tel. \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

2. Name: \_\_\_\_\_ Tel. \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, Private or other?

No, my child does not have health insurance. You may release my name and address  
To the NJ Family Care Program to contact me about health insurance.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

*Written consent required pursuant to 20U.S.C. §123g(b)(1) and 34 C.F.R. 99.30(b)*

NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply online or call 1-800-70-0710.

Yes, my child has health insurance.

I, the undersigned, do hereby authorize officials of Windsor Bergen Academy to contact directly the person named below 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 form, or parents/guardians 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 for said child.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

Any medical conditions, allergies, or concerns: \_\_\_\_\_

Local Physician's Name: \_\_\_\_\_  
(Please Print)

Address \_\_\_\_\_

Office Telephone No. \_\_\_\_\_

**\* Please contact Windsor Bergen Academy with any information regarding changes that relate to contact information.**