

VERNON TOWNSHIP SCHOOL DISTRICT

Dear Parents and/or Guardians:

Please complete, sign and return to your child's coach.

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Sport \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Mother's Work Number \_\_\_\_\_ Mom's Cell Phone Number \_\_\_\_\_ Father's Work Number \_\_\_\_\_

Dad's Cell Phone Number \_\_\_\_\_ Emergency Contact –Number 1- Name & Phone # \_\_\_\_\_

Emergency Contact- Number 2-Name & Phone # \_\_\_\_\_

ALLERGIES: Bee Sting Allergies: Yes\_\_ No\_\_ Food Allergies: Yes\_\_ No\_\_ Epi Pen: Yes\_\_ No\_\_ Other: \_\_\_\_\_

If your child uses an Epi-Pen or takes Medication of any kind, please contact the health office for the appropriate paperwork. These forms MUST be completed by your doctor. Kindly read and complete these forms and supply the necessary medications.

DIABETES: Yes\_\_ No\_\_ SEIZURE DISORDER: Yes\_\_ No\_\_ ASTHMA: Yes\_\_ No\_\_

DAILY MEDICATION/ HEALTH HISTORY: \_\_\_\_\_

INJURIES/ SURGERIES: \_\_\_\_\_

CONCUSSIONS: \_\_\_\_\_

DOCTOR \_\_\_\_\_ TELEPHONE \_\_\_\_\_

Parents/Guardians should be aware of the importance of obtaining a physical examination at least once during each of the student's developmental stages: early childhood (preschool – grade 3), pre-adolescence (grades 4-6) and adolescence (grade 7-12). Physician's release is required for re-entry to school following communicable diseases such as strep and chicken pox.

If you **DO NOT** want your child to have the following screenings indicate it below:

- 1. Vision, Hearing, Blood Pressure NO \_\_\_\_\_
- 2. Height and Weight NO \_\_\_\_\_
- 3. Scoliosis screening for 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup> and 11<sup>th</sup> graders NO \_\_\_\_\_

- If your child receives daily medication and will need it in school, please inform the school nurse. State regulations require written physician permission to take medication during school hours. If needed these forms MUST be completed by your doctor and can be found on the VTSD website. Kindly read and complete these forms and supply the necessary medications. Please contact the school nurse after the start of the school year, if you have any questions so that the proper forms can be completed. **NO MEDICATION CAN BE GIVEN WITHOUT A DOCTOR'S WRITTEN ORDER.**
- In the event the doctor(s) cannot be reached, you have my permission, and I hereby designate you my agent, to call any regularly licensed physician of the State of New Jersey. I hereby release you from any claim arising out of the doctor's actions, and I assume and agree to pay the doctor's charge for services and any charges incurred at the doctor's direction.

Does your child have Health Insurance including NJ Family Care/Medicaid, Medicare, private or other? Yes\_\_ No\_\_

If Yes, Name of Insurance Company \_\_\_\_\_

NJ Family Care provides free or low cost health insurance for uninsured children & 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 to contact me about health insurance. (Written consent required pursuant to 20 U.S.C. § 1232g (b) (1) and 34 C.F.R. 99.30 (b))
- I give permission for any important information to be shared with the necessary school personnel to insure my child's safety.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Date

