VERNON TOWNSHIP SCHOOL DISTRICT

Dear Parents and/or Guardians:

Please complete, sign and return to your child's homeroom teacher. This form must be completed for each school year

Student's Name_____ **Grade**_____ **Student ID#**_____**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 <u>DO NOT</u> 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 5th, 7th, 9th and 11th 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 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**