

North Warren Regional School District  
P.O. Box 410, 10 Noe Road  
Blairstown, NJ 07825

Emergency Information and Authorization

Check box if information has changed

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Sex: \_\_\_\_\_

Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

**NAME:** \_\_\_\_\_ **Telephone Number** \_\_\_\_\_

Father: \_\_\_\_\_  Home \_\_\_\_\_

Work \_\_\_\_\_  Cell \_\_\_\_\_

Mother: \_\_\_\_\_  Home \_\_\_\_\_

Work \_\_\_\_\_  Cell \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  Home \_\_\_\_\_

Work \_\_\_\_\_  Cell \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  Home \_\_\_\_\_

Work \_\_\_\_\_  Cell \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone: \_\_\_\_\_

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

Medical Conditions: \_\_\_\_\_

Medications and Reason: \_\_\_\_\_

**Insurance Information: If changed from previous year check here:** \_\_\_\_\_

Does child have health insurance?

Yes \_\_\_\_\_ If yes, name of insurance and ID# \_\_\_\_\_

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.

You may release my name and address to NJ Family Care 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)

By my signature below I acknowledge and agree that my son/daughter may be subject to random breath testing as a condition of participation in designated school function or activities in accordance with NWRHS policies and procedures. I also understand that I have the right to refuse permission for my child to be subject to random breath testing at these events but that in doing so I also preclude my child's participation in these activities.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

To the Board of Education, Superintendent, Principal, Designated Teacher in Charge, and School Nurse:

In the event that I am unable to be reached, and my child need Emergency Medical treatment during any time that he/she is at North Warren Regional, or a school-sponsered field trip, you have my permission and I hereby release you from any claim arising out of the doctor's actions, and I agree to pay for any professional medical services incurred if my child is not covered by school insurance.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_