

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:** _____