LOOKING GLASS CHILDREN'S CENTER

16 BELLEVUE AVENUE BLOOMFIELD, NEW JERSEY 07003 (973) 338.0264

EMERGENCY INFORMATION

Last Name _____ First _____ Initial_____ Birthday _____

Address _____

City _____Zip _____ Home Phone (_____) _____

To Parent/Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for EMERGENCY

Mother/Guardian

Name_____Relationship_____

Home Phone (_____)_____ Cell (_____)_____

Company: _____ Work Address: _____

Email: _____ Phone (_____)_____

Father/Guardian

Name_____Relationship_____

Home Phone (_____)_____ Cell (_____)_____

Company: _____ Work Address: _____

Email: _____ Phone (_____)_____

List two neighbors or nearby relatives who will assume temporary care of your child(ren) if you cannot be reached:

Neighbor/Relative 1 Name _____Address_____

Phone Numbers: Home (_____)_____ Cell (_____)_____Work (_____)_____

Work Address: _____Email: _____

Neighbor/Relative 1 Name _____Address_____

Phone Numbers: Home (_____)_____ Cell (_____)_____Work (_____)_____

Work Address: _____Email: _____

☐ Please check this box if there has been a name change of parent/guardian, address or telephone number. Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

☐ NO My child does not have health insurance. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ Printed Name: _____ Date: _____

Written consent required pursuant to 20 U.S.C.S. 1232g(b)(1) and 34C.F.R. 99.30(b). NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

☐ YES My child has health insurance.

List any medical/surgical care your child has received during the past year: _____

Dental Exam_____

Eye Exam _____

Allergy _____

Kind Medications_____

Allergic Reaction _____

Doctor _____ Phone_____

Dentist _____ Phone_____

Hospital _____ Phone_____

Hospital Name/Address _____

OUT OF STATE EMERGENCY CONTACT: (IN CASE OF MASS DISASTER AND EVACUATION):

NAME: _____RELATIONSHIP: _____

PHONE: _____ CITY/STATE: _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card 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 card, 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(s) / Guardian(s) Date

SCHOOL YEAR 2020 - 2021

Signature of Parent(s) / Guardian(s) Date