2017 - 2018

CONSENT FOR EMERGENCY MEDICAL TREATMENT

Student name: ____ M / F Grade: ________
(Please print) *(Circle one)*

- In case of accident or serious illness, I request the school nurse to contact me.
- If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions.
- If it is impossible to contact this physician, I give permission for my child to be transferred to the closest Emergency Room (ER) or trauma center (if necessary) where the ER doctor may assess, diagnose, and treat in order to provide comfort.
- Note: Surgical intervention will require parental/guardian permission unless the illness is life-threatening.

Family Physician's Name: ____

Address: ____

Phone Number: ____

Parent Name: (*please print*) ____

Parent Signature: ____ Date: _____________

HEALTH INSURANCE

Please initial in the space provided

Does your child have health insurance including private, NJ Family Care/Medicaid, Medicare or other?

☐ **YES** **My child has health insurance.**

Insurance Company: ____________________________ Name of Insured: ______________________________

Policy Number: ____________________________ Group Number: ______________________________

☐ **NO** **My child does *not* have health insurance.** Please note: NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, or to apply online, visit www.njfamilycare.org or call 1-800-701-0710. If you would like PCS to give your name and address to the *NJ FamilyCare Program,* so that they can send you information about health insurance, please sign below:

Parent Name: (*please print*) ____

Parent Signature: ____ Date: _____________