Pineland Learning Center
Emergency Medical Form

Student Name: _____ DOB: _____ Grade: _____

Please check the following conditions that apply to your child's health:

- ☐ Asthma [**Medication Y/N**]
- ☐ Diabetes [**Medication Y/N**]
- ☐ Heart Condition [**Restrictions Y/N**]
- ☐ Seizure Disorder
- ☐ Drug Allergies
- ☐ Food Allergies [**Epipen Y/N**]
- ☐ Seasonal Allergies [**Medication Y/N**]
- ☐ Glasses/Contacts [**Please Circle One**]
- ☐ Vision/Hearing Issues [**Please Circle One**]
- ☐ Other _____

Please provide additional medical information that is applicable to your child's health:

_____

_____

Please read carefully and circle the appropriate response for each of the following:

1. **Medication on Field Trips**. My child requires medication to be administered during school hours. I give permission for a certified staff supervisor to dispense medication to my child, in the event the nurse does not accompany students on school trip. . **YES NO**
2. **Over the Counter Medications.** I give permission for the school nurse to administer Tylenol / Ibuprofen (based on child's weight/age) to my child. **[If given more than three times in a month, a doctor's note will be required].** **YES NO**
3. **Sunscreen.** I give permission for the school staff to apply sunscreen to my child, following directions printed on product container. **YES NO**
4. **Emergency Treatment.** I understand in the event of an emergency, my child will be transported by ambulance to Inspira Medical Center (Vineland). I hereby give permission to begin emergency medical treatment in the event the school cannot reach me. **YES NO**

Please list any medications your child is currently taking:

Medicine: _____ Time & Dose: _____ Reason for Medication: _____

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Medicine: _____ Time & Dose: _____ Reason for Medication: _____

Medicine: _____ Time & Dose: _____ Reason for Medication: _____

Health Insurance Information:

☐ Yes, my child has Health Insurance. [NJ Family Care/Medicaid, Medicare, Private or Other. **Please Circle One**]

☐ No, my child does not have health insurance. You may release my name and address to NJ Family Care Program to contact me about health insurance.

Signature: _____ *Written consent required pursuant to 20 U.S.C. & 1232g(b)(1) and 34 C.F.R. 99.30(b)*

NJ Family Care 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.

Medical Contact Information:

Doctor's Name: _____

Address: _____

Phone: _____

Fax: _____

I hereby authorize officials of Pineland Learning Center to contact directly the persons named on this information sheet and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of my child. In the event that physicians or other persons named on this sheet or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the above child. I will not hold the school financially responsible for the emergency care and/or transportation for my child.

Parent/Guardian Legally Responsible: _____ Date: _____