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 explain the checked conditions above that apply to your child's health:

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Please describe any medical / surgical procedures your child has received in the last year:

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Please circle appropriate response for each of the following:

1. **Medication on Filed 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 650 mg / Ibuprofen 400 mg to my child, following directions printed on package. **[If given more than three times 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**
5. **Sharing Medical Information.** I give permission to release the above medical information to appropriate school personnel. **YES** **NO**

PLEASE COMPLETE PAGE 2 AND SIGN

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: _____________________

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: ___________________________________ Dentist's Name: _______________________________

Address: ____ Address: _____________________________________

Phone: ____ Phone: ______________________________________

Fax: ____ 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:** _____________________