

SCOTCH PLAINS FANWOOD PUBLIC SCHOOLS			
SCOTCH PLAINS-FANWOOD PUBLIC SCHOOLS—STUDENT EMERGENCY CONTACT CARD			
Student's Name (last/first)	Grade:	School Year: 20___/20___	
Sibling's Name (last/first)	School/Grade:		
Sibling's Name (last/first)	School/Grade:		
Sibling's Name (last/first)	School/Grade:		
Street:	Town:	Home Phone:	
Mother's Name: _____		Cell Phone:	Email:
_____		Email: _____	
Place of Business:	Work Phone:	Hours:	
Father's Name: _____		Cell Phone:	Email:
_____		Email: _____	
Place of Business:	Work Phone:	Hours:	
Please list two local friends or relatives who will be responsible for your child if parents cannot be reached:			
1. Name: _____	Address: _____	Home Phone: _____	
Relationship: _____	Cell Phone: _____	Work Phone: _____	
2. Name: _____	Address: _____	Home Phone: _____	
Relationship: _____	Cell Phone: _____	Work Phone: _____	
Upon an emergency early dismissal from school, please name two LOCAL neighbors, friends, or relatives to whom your child can report if you are not available (check here [] if same as above)			
1. Name: _____	Address: _____	Home Phone: _____	
Relationship: _____	Cell Phone: _____	Work Phone: _____	
2. Name: _____	Address: _____	Home Phone: _____	
Relationship: _____	Cell Phone: _____	Work Phone: _____	
Closest Relative:	Home Phone:	Cell:	Work Phone:

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OVER 

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3. Name: _____	Address: _____	Home Phone: _____	
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Relationship: _____	Cell Phone: _____	Work Phone: _____	
Closest Relative:	Home Phone:	Cell:	Work Phone:



Is there anything about the health of your child that the nurse should know? Yes No
 Any restrictions of physical activity? If yes, please explain:

Is there any health information you want to share with your child's teacher?

Is your child taking medication? Yes No If yes, please specify:

Child's Physician: _____ Phone: _____
 Physician's Address: _____ Hospital: _____
 Does your child have Health Insurance?
Yes ___ If yes, name of insurance company _____ Group ID# _____
No ___ NJ Family Care 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 to apply online.
 You may release my name and address to the NJ Family Care Program to contact me about health insurance.
Signature: _____ **Printed Name:** _____ **Date:** _____

Please indicate the **normal dismissal routine** from school for your child(ren) (check all that may apply):
 picked up by parent/guardian picked up by (insert name): _____
 walks home meets at a location on school grounds other than assigned dismissal door
 takes the school bus attends the FSP YMCA school-age child care program, or JCC after-school program
 drives self other (please provide specific details on space provided)

Date: _____ Signature of Parent/Guardian: _____

Is there anything about the health of your child that the nurse should know? Yes No
 Any restrictions of physical activity? If yes, please explain:

Is there any health information you want to share with your child's teacher?

Is your child taking medication? Yes No If yes, please specify:

Child's Physician: _____ Phone: _____
 Physician's Address: _____ Hospital: _____
 Does your child have Health Insurance?
Yes ___ If yes, name of insurance company _____ Group ID# _____
No ___ NJ Family Care 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 to apply online.
 You may release my name and address to the NJ Family Care Program to contact me about health insurance.
Signature: _____ **Printed Name:** _____ **Date:** _____

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