

**NORTHFIELD COMMUNITY SCHOOL HEALTH OFFICE**  
**EMERGENCY INFORMATION FORM**

**This form MUST be completed and returned to the school nurse as soon as possible**

**STUDENT NAME:** \_\_\_\_\_ **CURRENT GRADE:** \_\_\_\_\_

**MEDICAL INFORMATION:** *Please provide the following student information*

Does your child have Asthma? **Yes or No**      If yes, do they carry an Inhaler? **Yes or No**  
Nebulizer Treatments? **Yes or No**  
Any Allergies? \_\_\_\_\_ Reactions: \_\_\_\_\_

Does your child have an Epi-Pen? **Yes or No**  
Do they self-carry? **Yes or No** (if yes, updated doctor's note **MUST** be on file in health office)

Has your child ever had a seizure? **Yes or No** If yes, when & how frequently? \_\_\_\_\_

Has your child experienced a head injury of concussion? **Yes or No** If yes, when? \_\_\_\_\_

Is he/she presently on any medication? **Yes or No** If yes, what kind? \_\_\_\_\_

Does your child have any other illnesses or restrictions that the Health Office should be aware of?  
\_\_\_\_\_

Has your child ever been hospitalized OR had surgery? **Yes or No**  
If yes, when and for what? \_\_\_\_\_  
\_\_\_\_\_

Does your child have scoliosis? **Yes or No**  
Do you want your child to participate in the school scoliosis screening? **Yes or No**

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

Last Dental Exam: \_\_\_\_\_ Braces: **Yes or No**  
Date

Last Eye Exam: \_\_\_\_\_ Contacts: **Yes or No** Glasses: **Yes or No**  
Date

Recent Immunizations/Boosters \_\_\_\_\_  
Date Type

Doctor \_\_\_\_\_ Telephone # \_\_\_\_\_

Dentist \_\_\_\_\_ Telephone # \_\_\_\_\_

Hospital \_\_\_\_\_ Telephone # \_\_\_\_\_

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons 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 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/Guardian      Date      Cell Phone #