

2024-2025 Student Emergency Form

(This form needs to be completed EVERY school year)

****NOTIFY SCHOOL OFFICE OF ANY CHANGES DURING THE YEAR****

Date: ____/____/____

Date of Birth: ____/____/____

Student Name: _____
Last First Middle

Address: _____ Alpha _____ 08865
Street Address City Zip Code

Child Resides with: _____

Are there any legal documents affecting your child? Yes ___ No ___ If Yes, please attach documents.

Mother's/Guardian's Name: _____ Mother/Guardian will be contacted: 1st ___ 2nd ___

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Father's/Guardian's Name: _____ Father/Guardian will be contacted: 1st ___ 2nd ___

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contacts: In case the child listed above becomes ill or is injured at the school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following. These contacts will also be contacted if your child is absent from school without notification. They will be contacted in numerical order in case of emergency.

1. _____
Name Relationship Phone
2. _____
Name Relationship Phone
3. _____
Name Relationship Phone

Health Insurance

Does your child have health insurance? Yes _____ No _____ My child does not have health insurance. You may release my name and address to NJ FamilyCare Program to contact me about

Provider: _____

health insurance. NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online.

Date: _____ Printed Name: _____

Signature: _____

Written consent required pursuant to 20 U.S.C. § 1232g (b) (1) and 34 C.F.R. 99.30 (b).

In an emergency when parents cannot be reached, I authorize the school to call:
(Name, Address & Phone Number)

Physician / Clinical Facility: _____

Dentist: _____

Hospital: _____

Update Health Records: (List any medical/surgical care your child has received during the past year)

Recent Serious Illness

Recent Serious Hospitalization

Recent Immunizations

Restrictions

Recent Dental Exam (Date/Braces?)

Recent Eye Exam (Date/Contact/Glasses?)

Current Medications:

Yes _____ (Describe Below) No _____

Medication/Dosage

For What Condition

Allergies: _____

Additional Medical Notes:

I, the undersigned, do hereby authorize officials of Alpha Public School to contact directly the persons named on this form 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 form, 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.

Parent's / Guardian's Signature: _____ Date: _____

Alpha Public School
Permission/Authorization Form for Pre-School
2024-2025 School Year

Student Name: _____

For: Pre-School

This form will be kept in the main office for the 2024-2025 school year.

Field Trip Permission: Teachers will send home information prior to the date of each trip. This standard permission may be revoked or changed relative to each trip. It is the parents' choice whether students should attend trips.

I grant permission for my child to participate in field trips during the 2024-2025 school year. I understand that these trips will be adequately supervised by school staff, and they may be either a walking trip or transportation will be provided on safe, registered school buses operated by properly licensed drivers.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Photographic/Video Release: I grant Alpha Public School the right to use my child's photograph, either in video, print, or electronic format for any appropriate use in school materials, including, but not limited to, websites, newsletters, brochures, and marketing materials. This right can be transferred to third-party sources (such as local newspapers) for publicity reasons in the media and legitimate organizations partnering with the school. These rights are perpetual and not limited geographically. Of note, students' names (abbreviated or full) and grade level may appear on any internal and third-party sources materials as previously stated.

YES, I grant permission as stated above regarding my child for the 2024-2025 school year.

NO, I do not grant permission to the above regarding my child for the 2024-2025 school year.

NO, I do not grant permission to the above regarding my child for the 2024-2025 school year. However, I do grant permission to include my child's photograph and general information in the annual school yearbook.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

ALPHA PUBLIC SCHOOL
817 NORTH BLVD.
ALPHA, NJ 08865

School Nurse
Phone: (908) 454-5000 Ext. 205

Fax: (908) 454-4347

**PARENTAL AND PHYSICIAN'S AUTHORIZATION FOR
ADMINISTERING MEDICINES TO STUDENTS**

DO NOT RETURN THIS FORM UNLESS YOUR CHILD IS TO RECEIVE MEDICATION AT SCHOOL

A. To be completed by the Parent or Guardian:

I request that my child _____ in grade _____ receive medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication.

I do hereby release, discharge, and hold harmless Alpha School District, its agents and employees from any and all liability and claim whatsoever for the self-administration of the medication listed below as a result of any injury arising from self-medication.

Telephone Number _____ Date _____

Signature (Parent or Guardian) _____

B. To be completed by the Physician: (Must be written by physician only)

I request that my patient, as listed below, receive the following medication:

Name of pupil _____ DOB _____

Diagnosis _____

Name of medication _____

Prescribed dosage, means of administering, time to be taken during school hours:

Expected duration of treatment _____

Possible side effects and adverse reactions (if any) _____

Medication may be omitted during class trip if parent or nurse not available to administer
Please Check _____ Yes _____ No _____

Physician (please print) _____ Phone _____

Signature _____ Date _____

Stamp _____

Alpha Public School
817 North Blvd
Alpha, NJ 08865

Phone: 908-454-5000

Fax: 908-454-4347

Tylenol, Benadryl, & Tums
Administration in School

The school doctor has provided a standing-order to administer one or two 325mg tablets of **Tylenol** as needed for menstrual cramps/headache/pain. **Tums** – 1-2 tablets as needed for stomachache and heartburn. **Benadryl** – 1-2 tablets as needed for allergies or bee stings/bug bites. If any of these medications can be detrimental to your child's health or if there is a change in your child's health status, it is the responsibility of the parent to notify the School Nurse **in writing**.

If you want the nurse to administer Tylenol/Tums/Benadryl to your child for the **2024-2025** school year, please complete and sign the form below and have your child return it on the first day of school. The Nurse will have these medications available, you will not have to bring in your own. These medications will be used only if needed, ice for headaches and bug bites, ect. will be attempted first.

Thank you,

Laura Griffiths, BSN, RN, CSN-NJ
Alpha School Nurse

Please complete, sign and return to your homeroom teacher as soon as possible.

I give permission for the School Nurse at Alpha Public School to administer during the **2024-2025** school year.

Place an X next to what medication you would like the nurse to administer:

Tylenol _____

Tums _____

Benadryl _____

Students Name: _____

Signature of Parent/Guardian: _____ Date: _____