BOONTON HIGH SCHOOL EMERGENCY REFERENCE CARD

Student: _____ **Grade:** _____ **Date of Birth**: _____ **Sex**: ___ **Male** ___**Female**
(Last Name) (First Name)

Parent 1 Cell Phone #: _____Work Phone #: _____Email :_____

Parent 2 Cell Phone #: _____Work Phone #: _____Email :_____

I have arranged for the following people to be called in case of an emergency or illness if both parent(s)/guardian(s) are unavailable:

1. _____ Address: _____ Tel #: _____ Cell #: _____

2. _____ Address: _____ Tel #: _____ Cell #: _____

While your child attends public schools in Boonton, he/she will be examined at intervals by the school physician, with the school nurse in attendance.Male genitalia-hernia checks will be done as part of the school physical examinations for all middle and high school boys. All students in grades 4-12 will be screened annually for scoliosis. Such examinations are required and will be given by either the family physician or the school physician as soon as possible to all children in:

1. All fifth, eighth, and tenth grades
2. All new admissions to the school
3. All children with known physical defects
4. All students involved in interscholastic athletics
5. All students applying for working papers
6. Classified students and students being evaluated by Child Study Team when necessary

_____ **I wish to attend** _____ **I do not wish to attend**

Parent/Guardian Signature: _____ **Date:** _____

Does your child have a medical history:_____

Please submit a record of any immunizations received during the summer.
Please submit any physical exam done by your primary care provider for a school medical record update.

***Did your child have any illnesses or injuries which occurred during the past summer?** Yes_____ **(Please list below)** No____

Does your child have any ALLERGIES : _____

Bee Sting or other Insect Allergy _____Yes_____No_____ **Epipen**_____**Benadryl**_____

Food Allergies_____ **Epipen**_____**Benadryl**_____

Medication Allergies_____**Epipen**_____**Benadryl**_____

Has your child been diagnosed with ASTHMA? Yes ____No___ **Does your child use an Inhaler?** Yes ____ No____ **Nebulizer**____Yes____No

Is your child taking any DAILY MEDICATIONS?Yes ___No___ **(Please list below) Home administration** _____ **School administration**_____

May we call your family physician if necessary: Name: _____Tel #: _____

In the event of an emergency, if parent, guardian, or emergency numbers listed can't be reached, I give my permission to the school authority to arrange proper medical care at _____Hospital or other necessary medical/dental facility.

Is your child covered by Health Insurance? Yes _____ No_____ **Name of Insurance Company**_____

SIGNATURES OF BOTH PARENTS/GUARDIANS NECESSARY

Parent/Guardian 1 Print Name: _____ Relationship to Child: _____

Signature: _____ Date: _____

Parent/Guardian 2 Printed Name: _____Relationship to Child: _____

Signature: _____ Date: _____