08-D-21

BURLINGTON COUNTY INSTITUTE OF TECHNOLOGY

EMERGENCY INFORMATION FORM

Student _____ D.O.B. _____ Teacher _____

Male _____
Female _____
Grade _____

Home Address _____ Home phone # _____

Language spoken in home

City _____ State _____ Zip _____ if not English _____ Student lives with:

E-Mail Address _____ Cell Phone # _____

Mother _____
Father _____
Guardian _____

(Medical Home)NJAC6A:16-2.2(h)
Primary Physician _____ Phone # _____
(If different from student's)

Mother's/Guardian's Name _____ Address _____ Phone _____
(If different from student's)

Father's/Guardian's Name _____ Address _____ Phone _____

Mother's/Guardian's Place of Employment _____ Dept. _____ Phone: _____ Ext. _____

Friend, Relative, Child Care Provider, Neighbor available to pick up and care for child if parent/guardian cannot be reached: (use back of form for additional names)

Father's/Guardian's Place of Employment _____ Dept. _____ Phone: _____ Ext. _____

1. _____
Name Relationship Phone

2. _____
Name Relationship Phone

In case of accident or serious illness all reasonable efforts will be made to contact the parent/guardian. If necessary, the primary physician and/or 911 will be instituted and child will be sent to the nearest hospital.

When children become ill at school, it has been the policy of Burlington County Institute of Technology to send them home. On no occasion will a child be sent home if there is no one to care for him/her.

Students should have a physical examination that includes scoliosis screening done annually. If the student does not have a primary physician you may request BCIT to provide; annual scoilosis screening and a physical examination in the 10th grade.

My student does not have a primary physician and I am requesting:
_____Scoliosis screening _____10th grade physical examination

CURRENT MEDICAL HISTORY – All information will be shared with appropriate school personnel.

1. My child may___ may not___ Receive acetaminophen or ibuprofen, at the discretion of School Nurse in accordance with the protocol set by the School Physicians.

2. List any medications taken on a regular basis (prescription and nonprescription _____

_____

3. List any allergies (food, environmental, bee sting, medications, etc.) _____

_____

4. List any childhood diseases, serious illness, broken bones, sprains, hospitalizations or surgery this past year. _____

_____

5. List any disabilities (physical, emotional, learning, etc.) And/or physical restrictions _____

_____

6. Does your child have any of the following:

____ Anemia	____ Seizures	____ Heart Disease
____ Diabetes	____ Asthma	____ Heart Murmur
____ Nose Bleeds	____ Headaches	____ Neurological Problems
____ Eye Problems	____ Ear Problems	____ Speech Problems
____ Glasses	____ Bowel Problems	____ Urinary Problems
____ Contacts	____ Digestive Disorders	____ Orthopedic Problems
____ Menstrual Problems	____ Braces	

ALL CHECKED ITEMS MUST BE EXPLAINED _____

_____

Thank you for filling out and returning this form accurately and promptly to the school. If there are any changes during the school year please notify the school office immediately.

_____
Parent/Guardian Signature **Date**