

MEDICAL VERIFICATION LISTING INFORMATION TO BE UPDATED

REQUIRED BY STATE

The State of New Jersey requires that we obtain Health Insurance information for all of our students.

<p>Does your child _____ have any health insurance including (name of child) NJ FamilyCare/Medicaid, Medicare, private or other?</p> <p>Yes <input type="checkbox"/> If Yes, name of insurance company _____ Policy# _____</p> <p>No <input type="checkbox"/></p> <p>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.</p> <p>You may release my name and address to the NJ FamilyCare Program to contact me about health insurance. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>_____ Signature</p> <p>_____ Printed Name</p> <p>_____ Date</p> <p><i>Written consent required pursuant to 20 U.S.C. s 1232g (b)(1) and 34 C.F.R. 99.30 (b).</i></p>

REQUIRED BY SCHOOL

PLEASE UPDATE YOUR CHILD'S MEDICAL CONCERN(S)/INSURANCE INFORMATION THAT IS LISTED ABOVE:

DIAGNOSIS: _____

TREATING PHYSICIAN AND PHONE NUMBER: _____

PLEASE LIST ANY SPECIAL MEASURES NEEDED IN SCHOOL: _____

MEDICATION(S) NEEDED TO MANAGE HEALTH CONCERN(S): _____

ALLERGIES: _____

Parent/Guardian Signature