BERGENFIELD PUBLIC SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT
Roy W Brown Middle School / Bergenfield High School

Name of Student: _____ M ____ F ____ Grade _____
Last First

Address: _____ Date of Birth: ____/ ____/ ____
_____ Mo. Day Year
_____

1. Has your child ever attended a Bergenfield School? School Name _____
2. Has your child ever attended a school in New Jersey? Yes ____ No ____
3. Name and address of school transferring from _____
_____
_____
4. Grade transferred out _____
5. Please check any medical conditions that may pertain to your child.

_____ None
_____ Diabetes
_____ Seizures
_____ Asthma
_____ Heart Condition
_____ Gastrointestinal Disorder(s)
_____ Orthopedic Conditions
_____ Other - Please List

_____
_____

Please explain _____
_____
_____

6. Does your child require daily medication? Yes _____ No _____
If so, what medication? _____
7. Please note any measures that should be taken should an emergency arise from any of the noted medical conditions _____
_____
_____

8. I hereby give permission for the school to take necessary action in any extreme emergency. (I am aware that every effort will be made to contact the child's parent/guardian.) In the event of an emergency requiring an ambulance, the Bergenfield Ambulance Corp. will transport your child to Englewood, Hackensack Medical Center, or Holy Name Hospital.

Hospital Desired: Englewood _____ Hackensack Medical Center _____
Holy Name _____ Nearest Hospital _____

Name of Parent/Guardian (please print) _____
Signature of Parent/Guardian _____ Date _____

Please update this information, at any time, by notifying the School Nurse in writing.

12/2013