EMERGENCY CONTACT INFORMATION
2025-2026

Student Name: _____

Parent/Guardian: _____

Address: _____

Phone Numbers at Which Parent Can Be Reached:

1)_____ 2) _____ 3) _____

CONTACTS AND CUSTODY: NOTE: THIS SECOND MUST BE COMPLETED BY INDIVIDUALS WHO AGREE TO:

1)BE CONTACTED IN AN EMERGENCY

2)TAKE CUSTODY OF THE ABOVE-NAMED STUDENT IN AN EMERGENCY

I/ We agree to be contacted in an emergency, to accept custody of the above-named student and to provide information and assistance in resolving the emergency.

1)Name (Print)_____ 2) Name (Print)_____ 3) Name (Print)_____

Signature _____ Signature_____ Signature _____

Relationship _____ Relationship _____ Relationship _____

Phone _____ Phone_____ Phone _____

Address_____ Address_____ Address_____

Family Physician/Pediatrician: _____

Address: _____ Phone: _____

Medical Insurance Provider: _____
(e.g., Medicaid, Blue Cross/ Blue Shield)

Address: _____ Phone: _____

Name of Employer: _____

Address: _____ Phone: _____

I _____, the parent/guardian of _____
Grant permission for Jersey City Public Schools staff to secure emergency medical, psychiatric and/ or other services should they be needed and school staff is unable to contact me. I understand that my personal insurance will be primary with respect to the payment of any insurance benefits, while the Student Accident Program of Jersey City Public Schools will respond in an excess capacity. In the event that I have no insurance, Jersey City's School Accident Program will respond as the primary payer up to the limits of the policy.

If I cannot be contacted, my child can be placed in the custody of the person(s) Identified in the "Contacts and Custody" second of this form.

Parent Signature: _____ Date: _____