

**Nelsonville York City Schools**  
**First Aid and Emergency Medical Authorization**

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Grade/Teacher \_\_\_\_\_ / \_\_\_\_\_ Bus Driver/Bus# A.M.- \_\_\_\_\_ / \_\_\_\_\_

Bus Driver/Bus# P.M.- \_\_\_\_\_ / \_\_\_\_\_

Student Name \_\_\_\_\_ Birth Date- \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail- \_\_\_\_\_

**Residential Parent(s) or Guardian:**

Mother's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Beeper/Car#- \_\_\_\_\_

Address if different than Child's Address: \_\_\_\_\_ Zip- \_\_\_\_\_

Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Beeper/Car#- \_\_\_\_\_

Address if different than Child's Address: \_\_\_\_\_ Zip- \_\_\_\_\_

EMERGENCY CONTACTS: (TO WHOM CHILD MAY BE RELEASED TO IF PARENT IS UNAVAILABLE): Please make sure that you have discussed with the contact person that the school staff may need to request that your child be transported home in the event of an illness, injury or other situation that requires parental or custodial attention. Do not assume that a neighbor, friend or family member will be willing to share this responsibility without prior arrangements with the designated contact person.

Name(s) of Relative or Childcare Provider \_\_\_\_\_

Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Other \_\_\_\_\_

LIST ANY SPECIAL CONDITIONS, DISABILITIES, ALLERGIES, MEDICATIONS OR EMERGENCY MEDICAL INFORMATION THAT APPLIES TO YOUR CHILD:

\_\_\_\_\_

Preferred Sources of Medical Care:

Physician: \_\_\_\_\_ Phone #- \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone #- \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone # \_\_\_\_\_

CHILD'S HEALTH INSURANCE: \_\_\_\_\_ (Includes Healthy Start, Medicaid, etc.)

Subscriber's Name: \_\_\_\_\_ Identification Number- \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the above named doctors or in the event that the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. I give consent for the emergency contact person listed above TO ACT ON MY BEHALF until I am available. I agree to review and update this information whenever a change occurs.

Parent / Guardian Signature \_\_\_\_\_ Date- \_\_\_\_\_