Nelsonville-York City Schools

First Aid and Emergency Medical Authorization
2019-2020

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 parent or guardians cannot be reached.

Grade/Teacher _____ Bus # am _____ Bus # pm_____
Student's Name: _____ Birth Date: _____
Residential/Mailing Address: _____Zip:_____

Residential Parent(s) or Guardian: (**Circle** who should be called first)
Mother's name: _____ Home Phone#_____ Cell #_____
Address (if different than student's) _____ Zip: _____
Place of employment: _____ Work Phone #_____
Father's name: _____ Home Phone#_____ Cell #_____
Address (if different than student's) _____ Zip: _____
Place of employment: _____ Work Phone #_____

Emergency Contacts: (To whom child may be released to if parent is unavailable)
Please be sure that you inform the individuals you have listed on this form that 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. The school is not permitted to allow your child to leave school premises with any individual that is not on this list. In order to add or omit someone in the future you must make that request **in writing**.

Name	**Phone**	**Relationship to Student**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any special conditions, disabilities, allergies, medications or emergency medical information that applies to your child: _____
_____
_____

Physician: _____ Phone: _____ Fax: _____
Dentist: _____ Phone: _____ Fax: _____
Preferred Hospital: _____
Child's health insurance carrier: _____ (includes Healthy Start, Medicaid, etc.)
Subscriber's name: _____ ID # _____

Authorization to grant consent:
In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) administration of any treatment deemed necessary by the above named doctor(s) 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:** _____
Update: _____