**Jersey Shore Area School District**
**Authorization for First Aid/Emergency Care**

Date _____ Grade _____ Homeroom _____ Birth Date _____

Student Name _____ _____ _____ Phone _____
Last First Middle
Home Address _____ Email _____

Mother's Name _____ Work Place _____ Wk# _____
Cell# _____
Father's Name _____ Work Place _____ Wk# _____
Cell# _____

Child lives with: (please circle) Both Parents Father Mother Guardian Other _____

If school is unable to reach either of the above, please list 2 relatives or friends who you give the authority to advise and/or pick up your child if sick or injured:

Name/Relationship _____ Address _____ Phone _____
Name/Relationship _____ Address _____ Phone _____

## First Person to Contact _____

**EMERGENCY TREATMENT**

List any conditions your child may have, of which the school nurse should be aware: (Ex. Asthma, Seizure Disorder, Depression, Allergies, etc.)
_____

**BEE STING REACTION:**
Does your child have an allergy to bees which requires emergency medication? Yes No
If yes, please list medication used when stung: _____

**PERMISSION TO EXCHANGE INFORMATION:**
My child's health and/or medical information may be shared with school staff as needed so that in an emergency the staff can act in the best interest of my child.

_____
Signature Parent/Guardian

**EMERGENCY TREATMENT:**
If emergency treatment is required, the school authorities will use their judgment in sending the child to the nearest hospital.

_____
Signature Parent/Guardian