



## Little Shepherds Learning Community Emergency Medical Authorization

Student Name: \_\_\_\_\_

Class: \_\_\_\_\_ 2024-2025 School Year

I, the undersigned, being the parent and/or legal guardian of the child named above, do hereby consent to the participation of my child in all of the regularly scheduled activities of the school at Little Shepherds Learning Community including field trips, sporting events, and any other activities customarily associated with a school group.

I understand that I will be notified in the case of a medical emergency involving my child. However, in the event that I cannot be reached, I authorize the transport to the emergency room and the providing of necessary medical services in the event my child is injured or becomes ill.

I AUTHORIZE/DO NOT AUTHORIZE (circle one) any one of the alternative emergency contacts listed below to make emergency medical care decisions on behalf of my child if required by law or a health care provider. I understand that the school will not be responsible for medical expenses incurred.

A PDF OR PHOTOCOPY OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL

\_\_\_\_\_  
Parent/Guardian Signature and Date

**Please Note: Emergency Contacts Must be able to be at the school in 30 minutes or less and be able to drive should the need arise.**

**Emergency Contact:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **H/C**

**Emergency Contact:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **H/C**

**Hospital Preference:** \_\_\_\_\_

**Health Problems/Documented Allergies:** \_\_\_\_\_

**Developing the Light in Every Child**

**390 Rt. 57 West, Washington, NJ 07882**