

Emergency Medical Form

Hands-on Science Camp - August 9-13, 2010 - At the home of:
Space Domes America Director, Sharon Esker
3177 Dowling Dr.
Fairlawn, OH 44333
330-666-0919

Please call between 11:00 AM and 7:00 PM - Thanks!

List multiple children on the same form if contact/medical info is the same for all. ID special medical conditions.

EMERGENCY MEDICAL AUTHORIZATION FORM

Space Domes America

Student Name _____ Birth Date _____
Address _____ Camp Week Aug. 9-13, 2010
Age _____ Grade 2010/2011
Telephone _____ Drop Off Time _____ Pick Up _____

Please list the order of persons to be contacted in an emergency, including the parents.

First Contact:
Name _____ Relationship to Student _____ Daytime Phone(____) _____

Second Contact:
Name _____ Relationship to Student _____ Daytime Phone(____) _____

Third Contact:
Name _____ Relationship to Student _____ Daytime Phone(____) _____

Fourth Contact:
Name _____ Relationship to Student _____ Daytime Phone(____) _____

Name of Daytime Childcare Provider:
_____ Relationship to Student _____ Daytime Phone (____) _____

Street Address _____ City, State, Zip _____

Parents or Guardians: Authorize emergency treatment by signing one of the boxes below. Part I or Part II must be completed.

PART I: GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone (____) _____

Dentist _____ Phone (____) _____

Medical Specialist _____ Phone (____) _____

Local Hospital _____ Emergency Room Phone(____) _____

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 above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or, dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

Date _____ Signature of Parent/Guardian _____

PART II: REFUSE CONSENT

I do **not** give my consent for emergency medical treatment of my child. In the event of illness or injury regarding emergency treatment, I wish the school authorities to take the following action: _____

Date _____ Signature of Parent/Guardian _____

We offer snacks for before and after care students and drinks on hot days. Please list any food preferences your child might have (e.g. likes pretzels but not chocolate) as well as foods you prefer your child not have (e.g., pop, chocolate, gum) on the back of this paper. We will abide by parents' wishes. During lunch breaks students may view videos. We offer only "G" rated movies (e.g. *The Land Before Time* or *Finding Nemo*). If there are any specific children's movies you object to, please list them on the back of this paper. Thank You!

Please provide specific and detailed instructions concerning any allergies.