**Newark Catholic Summer Gym - 2024**
**June 3-6th & 10-12th (7 days total for PE credit) 8am until 4pm**
This form and fee of $100 are due by May 30th
to the school office, 740-344-3594

## Emergency Medical Authorization

STUDENT_____ (circle) **Male / Female** **Date of Birth**:_____

ADDRESS_____ CITY_____

***Contact in case of an Emergency***: name: _____ (___)_____

or: _____ (___)_____

Health Insurance _____Code (if needed)_____

## PART I to Grant consent for Emergency Treatment

**Student's medical history including allergies, medications being taken, and any physical impairment**
to which a physician should be alerted.

_____

In the event reasonable attempts to contact me at the above phone numbers have been unsuccessful, I hereby give my consent for:
**(1)** administration of any treatment deemed necessary by:

**(Physician)** Dr._____
Address_____
Telephone_(_____)_____
**(Dentist)** Dr._____
Address_____
Telephone_(_____)_____

If the designated preferred practitioner is not available, another licensed physician or dentist has my permission to give treatment.
**(2)** and the transfer of the child to (preferred hospital_____
(or 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 before the surgery is performed.

**Signature of Parent/Guardian** giving consent _____

Date _____

**********

**PART II REFUSAL to Grant Treatment**

I ***DO NOT*** give consent for Emergency Medical Treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

Signature of Parent _____ Date: _____