

**LEAVE NO SPACE BLANK
REQUIRED for every camper**



MEDICAL AUTHORIZATION

CAMPER'S NAME	BIRTH DATE	
SCHOOL	GRADE ENTERING	
ADDRESS		
TELEPHONE	Date of Last Physical	
Guardian 1	Daytime Phone	Other
Guardian 2	Daytime Phone	Other
Other Name	Daytime Phone	
Name of relative or childcare provider	Telephone	
Address	Relationship	
Medical Insurance: Company	Contract Number	

PURPOSE - To enable parents to authorize the emergency treatment for children who become ill or injured while under GLSC authority when guardians cannot be reached.

Authorization for Pick-Up

In the event that I cannot drop off or pick up my child for camp, I authorize the following persons to do so (please advise these individuals that a photo ID will be required before GLSC staff will release your child):

Name	Relationship	Telephone
Name	Relationship	Telephone
Signature of Guardian	Date:	

Great Summer Science Late Pickup policy

If a parent/guardian is more than 15 minutes late for pickup, the camper will be moved into the aftercare program and the parent/guardian will be billed the full aftercare payment of \$40. The parent/guardian will be billed the aftercare fee of \$40 for every fifteen minutes once the site has closed for the day.

Field Trip Permission

I give my permission for my child to participate in all of the activities associated with the summer camp session for which I have registered my child as described in the GLSC Great Summer Science 2008 Day Camps Brochure.

Signature of Guardian	Date
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Media Release

I give my permission for the Great Lakes Science Center to use photographs or similar media of my child for purposes of publicity and/or publications solely to promote the Great Lakes Science Center and its programs.

Signature of Guardian	Date
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Behavior Agreement

I, on behalf of myself and my minor child, agree to follow the rules of the Great Lakes Science Center and its staff during my minor child's participation in the Great Summer Science Camp Program. I understand that any child exhibiting behavior that may cause harm to themselves, other campers, or camp staff will be asked to leave the program without a refund. These behaviors include, but are not limited to, hitting, kicking, biting, sexual harassment and/or possessing weapons or illegal substances.

Signature of Guardian	Date
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Authorization to Share Records

I understand that minimum necessary information will be shared with camp staff personnel (including the Laurel School, Butler Campus Nurse for Laurel School, Butler Campus Campers). And, I agree to the release of any records necessary for emergency treatment.

Signature of Guardian	Date
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Please continue on other side

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PART I OR PART II MUST BE COMPLETED

PART I (To Grant Consent)

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

Doctor	Telephone
Dentist	Telephone
Medical Specialist	Telephone
Local Hospital	Telephone

In the event reasonable attempts to contact me at above phone number or the other guardians at the above phone number have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctors or above named preferred dentist, 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 the above preferred hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two 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, medication being taken**, and any **physical impairments** to which a physician should be alerted:

Medications being taken:

Wear glasses? YES NO Wears contacts? YES NO Uses an inhaler? YES NO Has an EPIPEN for allergic reaction? YES NO

IF YOUR CHILD USES AN EPI-EN OR INHALER PLEASE COPY AND RETURN THE SERIOUS ALLERGY OR ASTHMA MANAGEMENT CARE PLAN FOUND AT WWW.GREATSCIENCE.COM.

Signature of Parent/Guardian _____ Date _____

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II (Refusal of Consent)

I DO NOT GIVE MY CONSENT for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the GLSC authorities to take no action or to:

Signature of Parent/Guardian _____ Date _____