Drake Planetarium & Science Center
Program Registration Form

Program Name:____ Start Date: __________________

Name of Child ____

Name of Parent ____

Home Address ____

City, State ____________________ Zip Code: ___________ Email: ____________________

Home Phone:___________________ Daytime Phone: _______________ Cell Phone:___________

Student's Grade: _______ Age:___ Student's School:_______________ Teacher:_______________

Enclose full Program Fee with form - NO REFUNDS once child accepted into program.

Please return completed Registration and Medical Consent form with fee to: Drake Planetarium& Science Center
2020 Sherman Ave.
Norwood, Ohio 45212

Tel: 513-396-5578, Fax: 513-396-6486 Email: csteger@drakeplanetarium.org
Visit us on the Web at www.drakeplanetarium.org

☐ **I give permission for my child to be photographed during program sessions.**
☐ **I DO NOT give permission for my child to be photographed during program sessions.**

Medical Consent Form

Child's Name_______________________ Address_______________________ Phone___________

Emergency Medical Authorization Purpose: To enable parents & guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached. PART I OR PART II MUST BE COMPLETED.

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me at home phone________________ or mother's work phone ________________ or father's work phone ________________ have been unsuccessful, I hereby give my consent for:
1. The administration of any treatment deemed necessary by the preferred physician Dr. ________________ at ________________ (phone) or the preferred dentist Dr. ________________ at ________________ (phone) or in the event the designated practitioner is not available, by another physician or dentist.
2. The transfer of the child to the preferred hospital ________________ or any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring with the necessity for such surgery, are obtained prior to the performance of surgery.

FACTS CONCERNING THE CHILDS' MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS AND ANY PHYSICAL CONDITIONS TO WHICH THE PHYSICIAN AND SCHOOL SHOULD BE ALERTED:

____

____

Signature of parent or guardian________________________________ Date ,________________

PART I: REFUSAL TO CONSENT
(do not complete Part II if you completed Part I)

I do not give my consent for emergency medical treatment of my child. In the event of any illness or injury requiring treatment, I wish the school authorities to take no action or to ________________________________

____

____

Signature of parent or guardian________________________________ Date________________