Padua Franciscan High School
Summer PE Program 2019

July 8th – Jul 26th

Student Name _____ **Grade Fall 2019** ____
Last First

Address _____
Street City Zip

Home Phone _____ **Other Parent Phone** _____

Email _____ (student or parent – circle)

Signature of Student _____

I request that my son/daughter be enrolled in the Summer PE Program at Padua Franciscan High School. I understand that without exception he/she may miss a maximum of one day of class out of the 15 days scheduled; no credit is earned for this class with the second absence. I acknowledge that class times are 8:00am until noon daily. I also understand that **after the second day of class, no refund of the registration fee will be made**.

Signature of Parent _____ **Date** _____

PLEASE NOTE:

- Registration Fee of $150.00 must accompany this Registration Form, checks payable to Padua Franciscan High School.
- Return registration materials to the Business Office, personally or via mail – ATTN: Business Office.
- The Emergency Medical Authorization on the reverse side must be completed.
- **The Registration Period is May 20 to June 3.**
- Students will receive an enrollment confirmation letter mid-June.
- The first day of class is Monday, July 8. Students should be in regular Padua gym uniform (Gym Uniform consists of an appropriate mid-thigh length, loose fitting athletic shorts and any Padua imprinted t-shirt.

SCHOOL HEALTH SERVICES
EMERGENCY MEDICAL AUTHORIZATION

School: _____
Student Name_____ Telephone: _____
Address _____
School attended:_____ School year: _____

Purpose – To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Part I or Part II must be completed

PART I – TO GRANT REQUEST

In the event reasonable attempts to contact me at _____ or _____
Phone other parent
at _____ have been unsuccessful, I hereby give my consent for 1) the
Phone
administration of any treatment deemed necessary by Dr. _____ or
preferred physician
Dr. _____ in the event the designated preferred practitioner is not
preferred dentist
available, by another licensed physician or dentist; and 2) the transfer of the child to _____ or any hospital reasonably accessible.
preferred hospital

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 surgery is performed.

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** **Address**

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II – REFUSAL TO 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 school authorities to take no action or to:

_____
_____

Date **Signature of Parent** **Address**