

**NOTRE DAME-CATHEDRAL LATIN SCHOOL
AUTHORIZATION FOR MEDICAL TREATMENT
FOR PROGRAM PARTICIPANT**

I, _____ residing
at _____ Ohio, am the
parent and/or legal guardian of _____, (the "Participant"),
who resides at _____ Ohio, and is
participating in the **SENIOR CAREER EXPERIENCE** (the "Program"), on **MAY 21, 24, 25 and 26,
2010, at a site chosen by the student and family.**

I hereby give my consent for: (a) the administration of any medical or dental treatment to the Participant, during the Program, deemed necessary by a licensed physician or dentist and (b) the transfer of the Participant to any hospital reasonably accessible during the Program.

I understand that, in the event the Participant experiences a medical emergency during the Program, the site contact person will make reasonable efforts to contact me at _____ (telephone number), as soon as possible, but not necessarily before the actions described above have been taken.

This authorization does not cover any major surgery unless the medical opinions of two other licensed physicians or dentists are obtained, prior to such surgery being performed, and those opinions concur that surgery is a necessity.

Facts concerning the Participant's medical history, including allergies, medications being taken, the name and telephone number of the Participant's regular physician and dentist, any physical impairments, and any factors a physician should be alerted to are to be listed below:

Physician's Name & Telephone Number: _____

Dentist's Name & Telephone Number: _____

Other Pertinent Information: _____

Date

Parent and/or Legal Guardian Signature