BISHOP DWENGER HIGH SCHOOL

Bishop Dwenger High School
1300 E. Washington Center Road
Fort Wayne, IN 46825
260-496-4703

# SHADOW VISIT REGISTRATION

Dear Parent and Prospective Student:

Thank you for considering becoming a member of the Bishop Dwenger family. Choosing a high school is one of the most important decisions you and your child will make, and one that will have a major impact on your future.

We welcome **8th grade students as well as students considering transferring to Bishop Dwenger High School.** A Shadow Visit affords your son or daughter the opportunity to participate in a typical school day. We prefer that visits occur on Monday through Thursday. Shadow visits will be permitted between October and April. Shadows are discouraged on special schedule days due to the fact that we want you to have the most realistic experience while you are visiting Bishop Dwenger. You will need to contact Cindy Johnson in the Admissions Department, at 260-496-4703, to arrange a visitation day.

**T**he information below and the Emergency Information Form **must be** returned to the Admissions Department at least **one week prior** to your requested shadow date.

## IMPORTANT INFORMATION

1. Shadowing students must follow a student of the same gender and in the grade level above them.
2. This form must be filled out by the parent(s) of the visiting student.
3. Cindy Johnson, Admissions Coordinator, will call to confirm the visit the day before.
4. Bishop Dwenger dress code should be followed. Males should wear khaki pants, solid color dress shirt (white, black, lt. yellow, lt. blue, navy or gray) and tie; females should wear khaki pants and a polo shirt (same colors listed above). Preferably, student should wear shoes that are not tennis shoes or sandals, nor should they have open backs.

This form needs to be completed and returned ONE WEEK prior to the requested Shadow Date.

Student's Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Day Time Phone:_____ E-mail:_____

Grade:_____ School:_____

Interests:_____

Parent/Guardian Signature:_____

## MEDICAL: EMERGENCY MEDICAL CONSENT FORM

**Note:** Parents must sign either Part I (Consent…) or Part II (Authorization to notify of Refusal of Consent…) prior to the student's participation in Shadowing. Parents are responsible for updating the information on this form should changes occur before the Shadowing date.

**Part I. Consent to Emergency Medical Care**

Name of Child _____ School: _____ Grade_____
In the event of an emergency, I request that the school make reasonable attempts to contact me at_____ (phone number) or _____ (other parent/adult) at _____ (phone number).
I understand that in an emergency, exigent circumstances may prevent the school from contacting me immediately, or the school may be unable to reach me. I therefore consent to the school taking action which it deems necessary to secure emergency medical care/treatment for my child even if I have not been contacted.

I understand that decisions concerning the type of emergency medical care or treatment administered are made by health care providers and not by the school, and that exigent circumstances may require the administration of emergency medical care or treatment without my prior consent. However, I have indicated below any treatment preferences I have for my child, which the school may disclose to a health care provider. (Parents/guardians may check and complete any of the following):

_____ Dr. _____ is my preferred physician and Dr. _____ is my preferred dentist.
_____ _____ is my preferred hospital.
Receipt of my consent prior to my child receiving major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.
_____Other:

The school may also disclose the following checked information to a health care provider:
_____ Insurance information: Insurance Company Name _____
Policy/Group/Claim No. _____
_____ the following information regarding allergies my child has, medication my child is taking, and other medical facts about my child:

I understand that in the event of an emergency, the school will make reasonable efforts to notify a health care provider of the above-checked information, but I acknowledge that I am responsible for communicating such information to the appropriate medical personnel.

Date _____ Signature _____
(Parent/Guardian)

**********

**Part II. Refuse to Consent to Emergency Medical Care**
Name of Child: _____ School: _____ Grade _____
In the event of an emergency, I request that the school make reasonable attempts to contact me at_____ _____ (phone number) or _____ (other parent/adult) at _____ (phone number).

I understand that decisions concerning the administration of emergency care or treatment are made by health care providers and not the school. I do NOT want emergency medical treatment or care administered to my child. In the event of an emergency, I authorize the school to inform any health care providers of my wishes. While I understand that the school will make reasonable efforts to contact me and/or notify a health care provider of my wishes prior to the administration of any emergency medical care or treatment, I understand that exigent circumstances may prevent this. I also understand that I, not the school, am responsible for communicating my wishes to the appropriate medical personnel.

_____ _____
Date Parent/Guardian Signature