PARENT PERMISSION FORM
Job Shadow Experience

Name of Student: _____
Parent/Guardian Name: _____
Address: _____
City: _____ Zip: _____

Parent Home Phone: _____Work Phone: _____Pager:_____
Family Physician: _____ Physician Phone: _____
Insurance Company: _____ Policy Number: _____

Person to contact in an emergency if parent cannot be reached:

Name: _____ Phone: _____
Relationship to student: _____ Pager/cell #: _____

Does your child have any medical problems of which we should be aware?
Yes____No____ If yes, please describe:_____

_____

Does your child take any medications regularly? Yes_____ No_____

If yes, does your child need assistance in administering this medication? Yes____No_____

Parent's Statement: I hereby give my permission to my daughter/son to attend the designated job shadow experience. I understand that all school rules will be in force at all school-sponsored activities and assignments. In the event of injury or illness to my child while under the supervision of school personnel or an employer, I will be contacted for permission and directions regarding emergency treatment. If I cannot be contacted, my signature below indicates permission for any necessary treatment to be given.

Employer's Statement: The purpose of the Workers Disability Compensation Act in Michigan is to provide coverage to employees when they sustain injuries that arise out of, and in, the course of employment. Employers are required to carry workers' compensation insurance when they have one (1) full time or three (3) part time employees. Unpaid students and volunteers who are actually performing services (working) but without compensation may be covered under the Workers' Disability Compensation Act. Unpaid trainee and volunteer coverage under the Act would be determined on a case-by-case basis. Initials on this line indicate that this company subscribes to this coverage. _____

Approvals:

_____ _____
Student Date

_____ _____
Parent/Guardian Date

_____ _____
Coordinating Teacher Date