MEDICAL AUTHORIZATION for JOB SHADOW EXPERIENCE

To the parent: In order for your child to participate in a Job Shadow experience, this form must be filled out and returned to his or her job specialist.

Should it be necessary for my child to have medical treatment while participating in the job shadow experience, I hereby give the school district and workplace personnel permission to use their best judgment in obtaining medical service for my child, and I give permission to the physician selected by the school district personnel to render whatever medical treatment he or she deems necessary and appropriate. Permission is also granted to release necessary emergency contact/medical history to the attending physician, or to the workplace, if needed.

Student's Name: _____ Date of Birth: _____

Address: _____

Home Phone Number: _____

Name of Parents/Guardians: _____

Daytime Phone Number(s): _____

Contact Other than Parent/Guardian: _____

Daytime Phone Number: _____ Relationship to Student: _____

Family Doctor: _____ Phone Number:_____

List any special accommodations required by your child, including medical limitations, disability, dietary constraints or other restrictions:

Medical Authorization:

I, _____, hereby agree to all of the above authorizations

and permissions for my child, _____.

Signature: _____Date: _____