

Due to Guidance by February 11th

**Student Application and Initial Parental Consent Form**  
**KHS**  
**JOB SHADOW Day April 24, 2008**

These two forms are intended to indicate a sincere interest in participating in this event and must be returned by the 2/11 deadline in order for your child to participate. Host sites will be available on March 3<sup>rd</sup> and requests for particular sites will be due on March 10<sup>th</sup>. Once a student is placed in a position, parents must also provide written consent by signing the **Job Shadow Permission** form which will be distributed to students mid-March and due on April 2nd.

Student's Name \_\_\_\_\_ Current date \_\_\_\_\_

E-mail address \_\_\_\_\_ Phone number \_\_\_\_\_

English block: \_\_\_\_\_ Teacher \_\_\_\_\_ Room # \_\_\_\_\_

By signing the line below, I agree to write a resume to bring with me to the job shadowing site, complete a post shadowing survey through Naviance and write a thank you note within one week of my job shadow experience.

I am aware of the objectives of this program, and I understand that due to the availability of job shadowing sites, completing this application does not guarantee that the applicant will job shadow during this school year. Job shadowing is a privilege and is an optional opportunity. Students may be denied job shadowing because of behavioral issues, incomplete work and/or poor attendance.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

I understand and support my child's participation in the job shadowing program and am willing to provide necessary transportation or support my child driving to and from job shadowing experience.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

I grant the employer and school permission to photograph my child.

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Date

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**Student Name** \_\_\_\_\_

### Medical Authorization

Should it be necessary for my child to have medical treatment while participating in the job shadowing program, I hereby give the host company permission to use their best judgment in obtaining medical services. I give permission to the physician or emergency care selected to render whatever medical treatment he/she deems necessary and appropriate. I also agree to release the following emergency contact information to the attending physician or company.

Student Name  
Date of Birth  
Address  
Home phone  
Emergency Contact Phone Number/s

Emergency Contact Other Than Parent  
Relation to Student  
Phone Number/s  
Family Doctor  
Phone  
Preferred Hospital  
Address

Does your child have any special needs or require any specialized accommodations due to medical limitations, disabilities, dietary constraints, allergies or other restrictions?

- No
- Yes If yes, please explain:

I agree to all of the above authorizations and permissions.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Return this form ASAP or by February 11<sup>th</sup> to:

Heidi Cosmi-Godau, M.A.  
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