Medical Authorization Form

Should it be necessary for my child to receive medical treatment while participating in a Job Shadowing site visit, I hereby give the school district and workplace personnel permission to use their best judgment in obtaining medical service, and I give permission to the physician selected by the school district or workplace personnel to render whatever medical treatment he or she deems necessary and appropriate.

Permission also is granted to release necessary emergency contact/medical history to the attending physician, or to the workplace, if needed.

For your child to participate, you must provide the information requested below and return this form to the teacher before the scheduled site visit.

Student Name: ____

Address: ____

Home Phone: _______________________ Date of Birth: _____________________

Parent/Guardian Name: ____

Relation to Student: _______________________ Phone: ____________________

Additional Contact: ____

Relation to Student: _______________________ Phone: ____________________

Family Doctor: ___________________________ Phone: ____________________

Preferred Hospital: ___________________________ Phone: _________________

Does your child require any special accommodations because of medical limitations, disability, dietary constraints, or other restrictions? Please explain.

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I hereby agree to all of the above authorizations and permissions.

_______________________________ ____________________

Parent/Guardian Signature ***Date***