

**STUDENT JOB SHADOWING
PROGRAM RELEASE FORM**

You have requested to participate in:

(Event/Location)

(Date/Time)

In order for you to participate, this form must be filled out completely and returned prior to the event. NO STUDENT will be allowed to participate without a completed authorization form. Return to: Eileen Kuperavage, 91 S. Progress Avenue, Pottsville, PA 17901

Contact in case of Emergency:

Parent/Guardian

Parent/Guardian

Parent/Guardian

Name: _____

Home Phone: _____

Work Phone: _____

Family Physician: _____ Phone: _____

Hospital Preferred: _____

Special Medical Conditions or Allergies: _____

STATEMENT OF CONSENT:

I, _____, give my consent to participate in this event.
(Student's name)

In doing so, I agree to the following:

1. In case of a medical emergency, I grant the Supervisor the right to authorize medical care, if none of the persons named above can be reached.
2. This release is intended to discharge in advance, the Schuylkill School to Work Program and the Employer, that I am visiting from and against any and all liability arising out of or connected in any way with my participation in the Job Shadowing experience.

Date

Signature of Parent/Guardian

Date

Signature of Student