SAMPLE

Work-Based Learning

Medical Authorization

Office of Career and Technical Education

☐ Service-Learning ☐ Job Shadowing ☐ Internship ☐ Co-op
☐ Mentoring ☐ School Enterprise ☐ Entrepreneurship ☐ Apprenticeship

Should it be necessary for my child to have medical treatment while participating in the work-based learning activity checked above, I hereby give the school district and/or work-site personnel permission to use their best judgment in obtaining medical service for my child, and I give permission to the physician selected to render whatever medical treatment he/she deems necessary and appropriate.

☐ **Yes** ☐ **No**

Permission is also granted to release emergency contact/medical history to the attending physician or to work-site personnel if needed.

☐ **Yes** ☐ **No**

Student Information

Student's Name: Date:

Date of Birth:

Student's Street Address:

City: State: Zip:

Emergency Contact Information

Primary Emergency Contact Name(s):

Relation to Student:

Daytime Phone Number: Secondary Phone Number:

Secondary Emergency Contact Name(s):

Relation to Student:

Daytime Phone Number: Secondary Phone Number:

Medical/Insurance Information

Does the student have medical insurance? ☐ **Yes** ☐ **No**

Primary Care Physician's Name: Phone:

Medical Insurance Provider: Policy Number:

List any known allergies:

Does your child require any special accommodations due to medical limitations, allergies, disabilities, dietary constraints, or other restrictions? Please list any that are required:

Signature of Parent/Guardian: **Date:**

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