

PERMISSION SLIP

Dear Parent/Guardian:

Your daughter or son has been offered the opportunity to participate in a

job shadow workplace tour mentoring program
 internship other: _____

This experience will provide your child an opportunity to explore a career interest as well as apply his/her academic skills in a real work setting.

Your child has been invited to spend _____ hours, days, weeks at (workplace name and address):

Your son or daughter will be supervised by: _____ Phone: _____

Please note:

- Students are responsible for their own transportation to and from the worksite.
- The school will provide transportation to this worksite.

Participation in off campus Work-Based Learning experiences is to be considered the same as participation in regular school classes.

1. Students are subject to all rules and regulations of acceptable dress, grooming, behavior, and attendance.
2. Injuries resulting from activities at the off campus sites are to be handled in the same manner as if the class was on campus. Parents will be notified of any injury and treatment of the injury will be handled in accordance with parents' instructions or those on the school emergency cards. The parents' or guardians' insurance company will assume the primary medical coverage. If the student is an actual employee, the employer worker's compensation may be involved.

Please complete and return this form to _____ no later than _____.

Sincerely,

Name of Student _____ Parent or -uardian _____

Address _____ City _____ Zip _____

Parent(s) Home Phone _____ Work Phone _____ Pager # _____

Student's Social Security Number _____ - _____ - _____

Family Physician _____ Physician Phone _____

Insurance Company _____ Policy Number _____

Person to contact in an emergency, if parent cannot be reached:

Name _____ Phone _____

Relationship to student _____ Pager # _____

Does your child have any medical problems of which we should be aware?

Yes _____ No _____ If yes, please describe:

Does your child take any medications regularly? Yes _____ No _____

Does your child need assistance in administering this medication? Yes _____ No _____

PARENT'S STATEMENT:

I hereby give my permission for my daughter/son to attend all activities related to the designated learning experience. I understand that all school rules will be in force at all school sponsored activities and assignments. In the event of injury or illness to my child while under the supervision of school personnel or an employer, I will be contacted for permission and directions regarding emergency treatment. If I cannot be contacted, my signature below indicates permission for any necessary treatment to be given.

EMPLOYER'S STATEMENT:

The purpose of the Workers' Disability Compensation Act in Michigan is to provide coverage to employees when they sustain injuries that arise out of, and in, the course of employment. Employers are required to carry workers' compensation insurance when they have one (1) full-time or three (3) part-time employees. Paid cooperative education and apprenticeship participants would be covered under the Workers' Disability Compensation Act. Unpaid students and volunteers who are actually performing service (working), but without compensation, may also be covered under the Act. Unpaid trainee and volunteer coverage under the Act would be determined on a case-by-case basis. My company subscribes to this coverage.

APPROVALS:

Student

Date

Parent/Guardian of Student

Date

School Coordinator

Date

Employer Coordinator

Date