

EDMONDS SCHOOL DISTRICT #15
PARENT/GUARDIAN INFORMED CONSENT FOR JOB SHADOW EXPERIENCE



STUDENT AND JOB SHADOW LOCATION INFORMATION

Student's Name: _____ Phone: _____
Email Address _____ Cell Phone: _____
Mailing Address: _____ City: _____ Zip: _____
Student's School: EWHS LHS MHS MTHS SLHS
Job Shadow Location: _____
Job Shadow Address: _____
Job Shadow Supervisor: _____ Phone: _____
Supervisor Email Address: _____
Teacher: _____ Phone: _____

IN CASE OF A MEDICAL EMERGENCY:

Parent/Guardian's Name: _____ Day Phone: _____ Evening Phone: _____
Emergency Contact Person: _____ Phone: _____
Doctor's Name: _____ Phone: _____
List any Medications: _____ List any Allergies: _____
Other: _____
Name of Medical Insurance Carrier: _____ Phone: _____

PRIVATE TRANSPORTATION FOR JOB SHADOWING EXPERIENCES

Student and Parent/Guardian(s) acknowledge and agree that private transportation to and from the work-based learning site(s) is the complete, sole responsibility of the student and parent(s). The Edmonds School District assumes no responsibility for arranging such private transportation and will in no way participate in its planning and administration.

SIGNATURES:

_____	_____	_____	_____
Student's Signature	Date	Parent/Guardian's Signature	Date

*This signature authorizes emergency medical treatment and private transportation to Work-Based learning/work sites

The Edmonds School District, as an educational institution and as an employer does not discriminate on the basis of race, religion, ethnicity, national origin, age, disability, sex, marital or veteran status. This is a commitment made by the District in accordance with federal, state and local laws and regulations.