



## CAREER & TECHNICAL EDUCATION AREA



### Parent/Guardian Consent Form

Your son/daughter has enrolled in a Work Based Learning program offered through Twin Rivers Career and Technical Education Area. This document is intended to give permission for your child to participate in the program, realizing that each student must provide his/her own transportation to and from the work site and that your son/daughter must meet the application requirements to be accepted into the program.

#### Permission to Participate

\_\_\_\_\_ may participate in the WBL Program as specified in the Agreement and Training Plan, which will be completed once he/she is officially hired.

\_\_\_\_\_Yes \_\_\_\_\_No

#### Permission to Travel

As the parent/legal guardian of the above-named student, I hereby consent he/she may drive a private vehicle to and from the work site. I acknowledge that he/she is licensed to drive under the laws of the State of Indiana and agree to advise the school immediately if his/her driving privileges are suspended, revoked, or have expired without a timely renewal. I understand that automobile insurance is required.

\_\_\_\_\_Yes \_\_\_\_\_No

As the parent/legal guardian of the above named student, I hereby consent to allow him/her to ride with another student to the work site if needed.

\_\_\_\_\_Yes \_\_\_\_\_No

#### Vehicle Verification

Student's Driver's License # \_\_\_\_\_ License Plate # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Car Make/Model \_\_\_\_\_ Year \_\_\_\_\_

Policy Number \_\_\_\_\_

#### Photo Release

I grant permission for my son/daughter to be photographed or videotaped for promotional and educational purposes while participating in this program.

\_\_\_\_\_Yes \_\_\_\_\_No

## Medical Authorization and Insurance Information

Should it be necessary for my son/daughter to have medical treatment while participating in this program, I hereby give Twin Rivers CTE Area and/or the work site personnel permission to use their best judgment in obtaining medical services 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 the work site personnel, if needed.

\_\_\_\_\_Yes                      \_\_\_\_\_No

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

\_\_\_\_\_Yes                      \_\_\_\_\_No

Health Insurance Company \_\_\_\_\_

Name of Policyholder \_\_\_\_\_

Identification Number \_\_\_\_\_ Account Number \_\_\_\_\_

Name of Parent/Legal Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Does your son/daughter require any special accommodations because of medical limitations, disabilities, or other restrictions?

\_\_\_\_\_Yes                      \_\_\_\_\_No

If yes, please explain:

I hereby agree to waive and release any and all rights that I, my child, or our representatives may have to make claim against Twin Rivers CTE Area and or their respective officers, employees, or representatives arising from injury or damages, including attorney fees that may result from my child's participation in the Work Based Learning Program.

I further agree to indemnify and hold harmless Twin Rivers CTE Area and the work job site or their respective officers, employees, or representatives from any claims, including attorney fees, which I or my child might make or which might be made on my or our behalf by others, or which might be made against me or my child by others, arising from my child's participation in the Work Based Learning Program.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*