Internship Program Medical Release and Consent

Vail Unified School District

Student Name: _____

Parent/Legal Guardian Name: _____

In case of accident or serious illness, please contact the appropriate authorities and notify the emergency contacts in the order provided.

I understand that this consent and authorization hereby given and granted are continuing and are intended by me to extend throughout my student's participation in the Vail Internship Program. I also understand that this document will be shared with my student's mentor.

It is further understood that any expenses incurred will be paid for by the student's health insurance or the parent of the student. Payment of such expenses is not the school's responsibility.

_____ _____

Parent/Legal Guardian Signature Date

Emergency Contact Information

Name: _____ Relationship to Student: _____

Cell _____ Work _____ Home _____

Name: _____ Relationship to Student: _____

Cell _____ Work _____ Home _____

Name: _____ Relationship to Student: _____

Cell _____ Work _____ Home _____

Medical Information

Current Medical Conditions:

Medication or Food Allergies (describe reaction):

Current Medications and Dosage:

Hospital Preference:

It is the student's responsibility to return this form to the front office of his/her school site by end of day Wednesday, March 3rd.

Please retain a copy for your records.