PROOF OF INSURANCE

Name: _____D.O.B._____ M – F (circle)

Last First Initial Mo. Day Yr

Current Address_____

Street City State Zip

Home Phone: _____ Work Phone: _____

Family Physician_____ Phone:_____

Emergency Phone: _____ Contact Person: _____

Insurance Provider: _____

My son/daughter is covered by the insurance listed above and I will continue to keep it in force during the period he/she is involved in a job shadow,mentoring, or internship program: therefore , I do not wish to enroll in the School Accident Coverage Plan. I accept full responsibility for the cost of the treatment for any injury, which he/she may suffer while taking part in the program.

_____

Parent or Guaradian's Signature

INSURANCE WAIVER

Name: _____ D.O.B._____ M – F (circle)

Last First Initial Mo. Day Yr

Current Address_____

Street City State Zip

Home Phone: _____ Work Phone: _____

Family Physician_____ Phone:_____

Emergency Phone: _____ Contact Person: _____

Insurance Provider: _____

My son/daughter is not covered by private insurance and I do not wish to enroll in the School Accident Coverage Plan. I accept full responsibility for the cost of the treatment for any injury, which he/she may suffer while taking part in the job shadow, mentor, or internship program.

_____

Parent or Guardian's Signature