Summit Healthcare

Job Shadow Permission for an Individual Less than 18 years old

Individual's Name ____

Individual's Address ____
____
____

Individual's Date of Birth ___________________________ Individual's Date of Age __________________

Emergency Contact Details:

Name _________________________________ Relationship ____________________________________

Phone (cell) _____________________________ Phone (other) ___________________________________

I give permission for ____
to participate in a Job Shadow experience and for the information to be held and used by Summit Healthcare.
I give permission for medical attention to be sought in case of emergency.

Signature ____ Date _______________

Printed Name ____ Relationship __________________