



**MINOR STUDENT JOB SHADOW
PARENT/GUARDIAN AUTHORIZATION**

Date: _____

I hereby give permission for my son/daughter, (name) _____, to participate in the job shadowing experience at Black River Memorial Hospital. I certify that my son/daughter is _____ years of age and his/her birth date is _____.

I also authorize any health screening that is required for participation in the job shadow experience.

PARENT/GUARDIAN

Name Printed

Relationship

Signature

Date