

Gray Middle School
10400 US Hwy 42
Union, KY 41091
February 28, 2018

Dear Gray Middle School Parents,

We are planning a **Job Shadow Field Trip** with our eighth grade students to various Northern Kentucky and Greater Cincinnati businesses. The purpose of this trip is to expose students to various jobs. It is a great opportunity for the students to shadow employees in these companies in order to get a better understanding of the day-to-day activities of a career.

For all students, specific job location and descriptions will be randomly assigned prior to the field trip and sent home for your review. Job shadowing will be conducted on **March 23, 2018** departing Gray Middle School at 9:30am and return by 2:00pm. All students will be accompanied by one of their teachers at all times.

The cost of the trip is \$5.00 for busses and lunch. Your child must have their permission slip and money to their homeroom teacher by March 16, 2018. **No permission slip will be accepted after March 16, 2018.** It is important that we have an accurate count of students before finalizing companies for shadowing. If you have any questions please contact Heather Amon (heather.amon@boone.kyschools.us).

Sincerely,

Heather Amon
Careers Teacher

Please note, the back of this sheet must be signed along with the school permission slip.

Waiver of Liability Agreement and Parent/Guardian Consent Form

As a parent/guardian of the below-named child participating in the Junior Achievement Job Shadow event which will take place at _____ (Company) on **March 23**, 2018 between the hours of 10 a.m. and 1 p.m., with additional travel time. I understand that this Waiver of Liability Agreement (Waiver) and Parent/Guardian Consent form must be signed by me in order for my child to participate in the Job Shadow event.

For purposes of this Waiver, the above-named business/organization (Company) shall include any of its affiliated companies and all of its directors, officers, agents and employees. Similarly, the term "JA Worldwide, Junior Achievement" shall include any of its affiliated companies and all of its directors, officers, agents, volunteers and employees.

By permitting my child to participate in this Job Shadow program, I understand that I assume all responsibility and risk associated with all conditions, hazards and potential dangers associated with being on or about the Company facilities or work sites, whether the dangers are open and obvious or concealed. I release, discharge, and waive any claims, actions, or suits of any character, name and description that I and/or my minor child(ren) may have against the Company or JA Worldwide, Junior Achievement as a result of any injuries, damages or death received or sustained.

Photo Release:

I grant the Company/JA Worldwide and/or Junior Achievement unrestricted permission to photograph and/or videotape my child(ren) participating in the Job Shadow event to use the photographs, videos and/or my child's quotes regarding participation in the Job Shadow event in public media for promotional and educational purposes. This may include, but is not limited to, use on a company website, Facebook and/or LinkedIn pages. By signing this agreement on behalf of a minor I am giving the above-named business/organization (Company) and/or JA Worldwide, Junior Achievement the right to use the minor's name and own the images containing the minor and use them for promotional and educational purposes without further approval from me. I am releasing all rights to any images.

Yes _____ No _____

Medical Authorization

Should it be necessary for my child to have medical treatment while participating in the Job Shadow event, the Company and Junior Achievement and/or the chaperoning teacher/parent will contact the school to get contact information for the students as well as details for where the family would like medical attention to be given.

By signing this, I hereby agree to all of the above authorizations and permissions, and to the photo release as indicated.

Furthermore, I have read and fully understand this Waiver and Consent form, and have not been offered any additional consideration or enticement, nor have I been coerced to execute this Waiver, and I execute this Waiver fully for the purposes and considerations described.

Executed this ____ day of _____, 2018.

Printed Name of Student

Signature

Printed Name of parent/guardian

Signature

Boone County Schools Field Trip Permission Form Rev 10/27/2014

Student's Name: _____

Grade: 8th Teacher: Mrs. Amon

My son/daughter has permission to attend the field trip to _____

Job Shadow on March 23rd

from 9:30 (departure time) to 1:30 (date) (arrival time).

In case of emergency, you may reach us by telephoning: _____

Or by contacting: _____ Phone #: _____

Will it be necessary for your child to take medication while on the Field Trip?

Yes No

If Yes, please complete a Medication Administration Consent form for each medication, unless already on file at school for the current school year.

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and follow his/her instructions. If unable to contact this physician, the school may take whatever arrangements that seem necessary. I understand that trained Boone County School staff will be delegated to assist with/administer medication(s) required for this field trip. All medications needed must be provided by the parent/guardian.

Parent/guardian signature: _____ Date: _____

Physician Name: _____

Address: _____

Office Phone Number: _____

Insurance Company: _____

Insurance Policy #: _____ Member ID: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Please note health condition(s) and drug, food or other allergies: _____

The Board of Education maintains adequate insurance coverage for all school-related activities. However, individual medical insurance is the parent's responsibility. Your local insurance agent could provide individual trip insurance.

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Boone County Schools
 Student Services Division
 School Health Services Department

Medication Administration Consent Form
 In-school/After-school hours/Field trip including self-administration

Dear Parents/Guardians:

Prescribed medications (prescription, herbal and dietary supplements alike) ordered by a physician and non-prescription over-the-counter medications which are essential for the student to take during and/or after school hours while attending a school-sponsored event/field trip shall be given according to the instructions written below. All prescribed and non-prescription medications shall be kept in an approved area at school or with an adult who is a Boone County school employee on a field trip unless the student has permission to carry emergency medication signed by a physician. Prescription medication over-the-counter medications must be in the original container and marked with the student's name. No more than one week's supply of medicine may be received at school; for a field trip send in only the amount of medication required for the after-school event/field trip. All unauthorized medications will be confiscated. This form may be faxed to the school office by your doctor. Please refer to the District's medication policy and procedures for more detailed information.

Student's Name: _____ Date of birth: ____/____/____ Grade: _____

Name of Medication: _____ Diagnosis/condition: _____

Dose (specify amount in mg or ml): _____ Time(s) to be administered: _____ Route: _____

Please note any potential reactions or side effects the child might have to this medication: _____

Special storage requirements: _____ ALLERGENS: _____

Specific to field trips: In the case of field trips or school-related functions, slight adaptations to the time the medication is administered may also be necessary. Unless indicated otherwise, students may self-administer medication with school trained personnel supervision while on a field trip.

I request trained Boone County School employees to administer or supervise the administration of this medication in accordance with Boone County Schools' Medication Administration Guidelines and the above instructions. I release Boone County School District and any of its employees (hereinafter the "District") from any liability or harm which is suffered by the student (named above) as a result of this request. I further agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

Parent Signature _____ Parent Phone Number _____ Date _____

Physician name _____ Date _____

Physician Signature (required for prescribed medications and self-administration of any medication) _____ Date _____

Physician Address _____ Phone Number _____

Revised Apr. 2015

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 Student Services Division
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