MAYO CLINIC

Career Observation Program

PARENT/GUARDIAN CONSENT FORM

Travel/Release from Liability/Photo Release/Medical Authorization

Student Name: _____

Student SSN: _____ **Student Date of Birth:** _____

High School: _____

- My child has my permission to participate in the Mayo Clinic Career Observation Program.
- I am aware that participation in this program requires travel to Mayo Clinic and I release Mayo Clinic from any liability associated with that travel.
- This is a school/Mayo Clinic-sponsored program in which my child understands the need for respectful conduct and professional attire during all times of this program.
- I give permission for my son/daughter to be photographed or videotaped during this program to be used later for promotional or educational purposes.
- Should it be necessary for my child to have medical treatment while participating in the Mayo Clinic Career Observation Program, I hereby give Mayo Clinic staff members' permission to use their best judgment in obtaining medical services for my child.

I agree to the above statements and consent form.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Please Print Name Daytime Phone

October 2022

Mayo Clinic | Mayo Clinic School of Health Sciences
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