Summer Internship Program
Parental / Guardian Consent

I hereby give consent for ____ to participate in the summer internship program at Iowa Specialty Hospital and Clinics. I understand that if my son/daughter missed 5 days of unexcused absences he/she will be removed from the program.

Does your child have any special health problems/concerns? Yes: ____ No: _____

If yes, please explain: ____

Summer Internship Parental / Guardian Contact Information:

Relationship: ____

Address: ____

Home Phone: _________________________ Cell Phone: ______________________

Work Phone: ____

Parent/Guardian name (please print): _____________________________________

Parent/Guardian Signature: _______________________________Date: _________

Parent/Guardian Email Address: ____