

**WORK-BASED LEARNING CONTRACT – ADDENDUM B
COVERING INSURANCE AND EMERGENCY INFORMATION**

Student's Name: _____ Birth Date: _____
 Student's Home Address: _____ City: _____ State/Zip: _____
 Student's Social Security Number: _____ Home Phone: _____
 School Name: _____ School Address: _____

To become eligible for work-based learning, the Chandler Unified School District requires that the student/trainee have adequate medical insurance coverage. This requirement may be fulfilled in one of two ways:

- 1) Purchase an insurance policy through the school site; or
- 2) Complete the below information and waiver if the student has adequate insurance coverage.

The student/trainee stated above will be insured through: _____ School Insurance _____ Other Insurance
 If **other insurance** is checked, please complete the below waiver and information:

The below listed policy will completely absolve the School Board and the District of an insurance liability. I further accept full responsibility for all obligations, financial or otherwise, which may result from on-the-job injuries to aforesaid student/trainee during the _____ school year not covered by the training station's policy. I further certify that I have read and currently understand my current health and accident insurance policy and am aware of its coverage and limitations in relation to injuries received as a result of participation in the Work-Based Learning Program by the aforesaid member of my family.

Type of Insurance Coverage	Indicate who is providing coverage or not applicable with an (X).			
	<u>Family</u>	<u>School</u>	<u>Employer</u>	<u>N/A</u>
Liability and/or Bonding	_____	_____	_____	_____
Worker's Compensation	_____	_____	_____	_____
Health/Accident Insurance	_____	_____	_____	_____

Any insurance provided by family and/or employer shall be primary relative to insurance provided by school (if any) and such insurance provided by school (if any) shall not contribute to insurance provided by family and/or employer.

Name of Health/Accident Insurance Company _____

List medical information about the student that would be helpful in case of an emergency: _____

Allergic to medications: ____ Yes ____ No If yes, list medications: _____

List any allergies or other medical problems that may exist: _____

Parent/Guardian Name: _____ Cell Phone: _____
 Work Name: _____ Work Phone: _____

Parent/Guardian Name: _____ Cell Phone: _____
 Work Name: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____

I consent for my child to receive emergency treatment in case of injury or illness. The information provided is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____