INTERNSHIP Insurance Acknowledgement Agreement

Student Name:	**Age:**
Mailing Address:	
Parent/Guardian Phone:	**Parent/Guardian E-mail:**

Mentor's Name:	**Business Name:**

Dysart Unified School District's liability insurance covers only the District, its assets, and its agents (employees and board members). I understand that my student will be leaving school to participate in a workplace setting under the Dysart Unified School District's Work Based Learning Program, and the District's liability insurance will not cover my student. I am responsible and liable for my student's actions while at the workplace or traveling to and from the workplace.

My student's assigned workplace may involve health and safety hazards. Dysart Unified School District does not provide health insurance for students. I have been advised that student health insurance is not the responsibility of the District and I am responsible for any insurance coverage for my student during participation in the Work Based Learning Program.

By signing, I acknowledge that I have read and understood the District's position on insurance pertaining to my student.

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Student Signature Date Parent/Guardian Signature Date

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Parent/Guardian Name (Please Print)