



Capital Health

TAKE OUR KIDS TO WORK™ GRADE 9 CAREER DAY

Waiver Form

Child's Name: _____ Age: _____

Parent's/Guardian's Name: _____ Work # _____

Department: _____ Site: _____

Please indicate if your child has a medical condition: _____

I would like my child to participate in Take Our Kids To Work Day™. In consideration for my child's participation, I, for myself, my heirs, agents, executors and administrators, hereby waive and release any and all causes of action at law or in equity, rights and claims or damages or other relief I have or may in the future have against the Capital District Health Authority, its representatives and successors, as a result of our participation in this event.

Your manager must approve whether it is appropriate to bring your child to work to job shadow you.

Parent/Guardian

Signature: _____ Date: _____

Please return this waiver form to your manager.

If you have any questions or concerns, please contact People Services at 473-5757 (option 4)