

**Champlain Valley Area Health Education Center**  
**Shadow Day Program**  
**FAHC Shadow Day Applicant-Guardian Agreement**

Student's email address: \_\_\_\_\_

**Student** I certify that the information given in this application is true and correct. I have given the reference form to a school professional to complete. If I am accepted to attend the event, I agree to a) promptly respond to the attendance confirmation email, b) pay the non-refundable event fee of \$25 (or less, if assistance is needed and a partial scholarship is provided), and c) complete assigned readings prior to the day. I also agree to observe health and safety rules, participate in discussions and activities, and listen to and encourage other student participants.

**Name (print)** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Parent/Guardian** I give my son/daughter/ward permission to apply for admission to the *Shadow Day*. I give Champlain Valley AHEC and my child's reference permission to discuss my son/daughter/ward's readiness to participate in this event. If my son/daughter/ward is accepted to attend the event I will a) help fill out and return the attendance confirmation informational email, b) pay the non-refundable conference fee of \$25 (due with attendance confirmation, minus any scholarship funds that may be awarded to students in need), and c) provide transportation to and from the event at my expense.

**Name (print)** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

→ **Please return to** Champlain Valley Area Health Education Center, 92 Fairfield St., St. Albans, VT 05478, or fax to (802) 527 – 1632, **before March 28<sup>th</sup>**. Questions: Call (802) 527-1474