

LOWER DAUPHIN SCHOOL DISTRICT  
WORK EXPERIENCE PROGRAM  
INSURANCE CERTIFICATE

The Lower Dauphin School District and the U.S. Department of Labor Regulations requires all students who participate in the Work Experience Program to have current medical insurance.

PLEASE CHECK ONLY ONE OPTION SIGN, DATE, AND RETURN THIS FORM TO THE WORK EXPERIENCE OFFICE.

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\_\_\_\_\_ Option #1 **Personal Insurance Coverage**

My son/daughter is covered by an insurance policy, and I assume full responsibility for all related expenses for any injuries that occur.

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\_\_\_\_\_ Option #2 **School Insurance Coverage**

My son/daughter is covered by the student accident insurance program made available through the Lower Dauphin School District.

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\_\_\_\_\_ Option #3 **PA ACCESS Card**

My son/daughter is covered by a PA Access card.

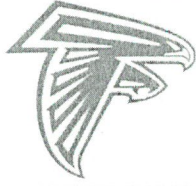
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\_\_\_\_\_ Option #4 **NO Personal Insurance Coverage**

My son/daughter is not covered by a personal insurance policy, school insurance, or PA Access card.

\_\_\_\_\_  
(Parent/guardian signature)

\_\_\_\_\_  
(Date)



**LOWER DAUPHIN SCHOOL DISTRICT  
WORK EXPERIENCE PROGRAM**

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**INTERN/WORK PROGRAM**

**DRIVING PERMISSION**

Karee Robinson  
Transition Coordinator  
Lower Dauphin High School  
201 South Hanover Street  
Hummelstown, PA 17036

(Phone) 717-566-5330

(Fax) 717-566-3970

E-mail: [krobinson@ldsd.org](mailto:krobinson@ldsd.org)

I/WE, THE PARENT(S)/GUARDIAN OF \_\_\_\_\_  
*(Student's Name)*

WHO PRESENTLY ENROLLED IN THE INTERNSHIP or WORK

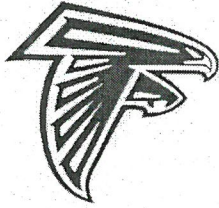
EXPERIENCE PROGRAM, GIVE PERMISSION FOR

\_\_\_\_\_ TO BE TRANSPORTED BY LOWER  
*(Student's Name)*

DAUPHIN SCHOOL DISTRICT TO PLACE OF WORK OR HOME.

\_\_\_\_\_  
*(Signature of parent or guardian)*

\_\_\_\_\_  
*(date)*



## STUDENT/PARENT RESPONSIBILITY ACKNOWLEDGEMENT FORM

We, the undersigned, have read and understand the Work Experience Policy and Procedures governing the operation of the LDS Work Experience Program. We understand that any violations of these policies will result in the school taking action against the student as stated in the code. We understand that removal from the Work Experience Program could jeopardize the student's credits necessary for graduation.

*(Please Print)*

Student's Name: \_\_\_\_\_

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Work Experience Coordinator's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE KEEP YOUR COPY OF THE  
WORK EXPERIENCE POLICY AND  
PROCEDURES FOR REFERENCE  
DURING THE SCHOOL YEAR.**