PERMISSION TO PARTICIPATE IN DISABILITY MENTORING DAY

My son/daughter, _____, may participate in a DMD Event, sponsored by Beyond Barriers, Ks. (located at 115 East 4th, Hutchinson, Kansas, 67501) which will take place on **Wednesday, October 15, 2025** from **8:00 AM to 3:00 PM.**

Name of Parent/Guardian:

_____

Address:

_____

_____

Work #: _____ Home #: _____

_____ _____
Signature Date

PHOTO RELEASE. I further understand that DMD can attract attention from the media and that it is used to promote ongoing partnerships between schools, disability organizations, and employers. I hereby grant permission to photograph my above-mentioned son/daughter for promotional and educational purposes.

_____ _____
Signature Date

MEDICAL AUTHORIZATION

In order for you (age 18 and over) or your son/daughter (under 18) to participate in the Disability Mentoring Day (DMD) event at Beyond Barriers, Ks, you must fill out this form and return it to the Employer Coordinator, Cindy Daniels.

Should it be necessary for me or my son/daughter to have medical treatment while participating in an DMD event at Beyond Barriers, Ks, I hereby give permission to the Employment Coordinator, Cindy Daniels, to use her best judgment in obtaining medical service for me or my son/daughter, and I give permission to the chosen medical personnel to render whatever medical treatment he or she deems necessary and appropriate. Permission is also granted to release necessary emergency contact/medical history to the attending physician, or to the workplace, if needed.

Name of Mentee: _____

Date of Birth: _____

Parent/Guardian (if Mentee is under 18):

_____

Relation to Mentee: _____

Phone #: _____

Family/Personal Doctor: _____

Phone #: _____

Preferred Hospital: _____

Phone #: _____

Do you or your son/daughter require any special accommodations? Please explain.

_____

_____

_____

I hereby agree to all of the above authorizations and permission.

_____
Signature of Mentee (18 or over)

_____
Parent/Guardian (under 18)

_____
Date