

**APPLICATION FOR WORKING PERMIT**

Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

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**EMPLOYER'S STATEMENT**

I would like to employ \_\_\_\_\_.

He/she will work as (job description) \_\_\_\_\_ for \_\_\_\_\_ on school days and \_\_\_\_\_ on weekends.

FIRM NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

Employer's Signature \_\_\_\_\_

Note: Students attending school are allowed to work three (3) hours on school days and not after 9:00 PM, and eight (8) hours on both Saturday and Sunday. The above named student shall not engage in any activity prohibited by any statute or rule or regulations of the Department of Labor in regard to the Child Labor Laws of this State.

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**CONCENT OF PARENT OR GUARDIAN**

I hereby give my consent to my son/daughter or ward to engage in part-time employment at the above-mentioned firm and agree to comply with the stated regulations and laws applicable to the specific type of employment for which this application is being submitted.

I give High School District 214 permission to release any and all medical report information commensurate with Illinois Revised Statutes, Chapter 48, Section 31.12, sub-section (d) (4), it deems necessary in connection and for the sole purpose of my child or ward obtaining an employment certificate as that term is defined under the Child Labor Laws of the State of Illinois.

Any description of a prior or existing physical condition which may, in the judgment of the School District and/or student's physician, be the basis for limiting the issue of the employment certificate shall not constitute a violation of any right of a student which is guaranteed under the Family Educational Right to Privacy Act.

\_\_\_\_\_  
(Signature of Parent)

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Name of student \_\_\_\_\_

**MEDICAL REPORT** (To be obtained from school nurse)

Upon reviewing of doctor \_\_\_\_\_ physical examination of \_\_\_\_\_  
(Name of Doctor) (Date)

the following doctor's comments and/or statement of limitations were noted:

\_\_\_\_\_  
(School Nurse Signature)

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

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Giving incorrect or improper information on this form shall constitute a Class "C" misdemeanor pursuant to the laws of the state of Illinois.

**\*PLEASE BRING BIRTH CERTIFICATE ALONG WITH THIS FORM IN ORDER TO SECURE WORKING PERMIT\***

**(ALL THE ABOVE INFORMATION MUST BE COMPLETED BEFORE A CERTIFICATE OF AGE CAN BE ISSUED)**