

Pope John Paul the Great Catholic High School

Shadow Day Request Form



Our Shadow Days are generally on Thursdays from 7:30 a.m. until 2:30 p.m. Please check the Admissions page of our web site for current possible dates.

Please state which dates you prefer:

1st Choice: ___/___/___ 2nd Choice: ___/___/___

Student Information

Student Last Name	Student First Name	Student Middle Name
Home Address	City	
State	Zip code	Home Phone
Current School	8 9 10 Current Grade	M F Gender

What are your *three* favorite academic subjects? Please also list any Honors or AP classes you are currently enrolled in.

What are your *top three* favorite sports and/or clubs?

What is most important to you about the high school you will attend?

Do you have a sibling, relative, or friend attending JP the Great? Please provide his/her name and grade:

Is there a particular student who you would like to shadow? Please provide his/her name and grade:

We will try our best to accommodate your request. Please note that we typically pair students of the same gender together.

Parent/Guardian Information

Parent(s)/Guardian(s) Names

Home Phone

Cell or Work Phone(s):

Email Address:

- Please continue on reverse -

Emergency Contact/Medical Information:

1 st Emergency Contact Name	2 nd Emergency Contact Name		
Relationship to Student	Phone Number	Relationship to Student	Phone Number
Student's Physician	Physician's Phone		
Medical Insurance Co	Policy Number		

If applicable, please list your son/daughter's allergies

Parent/Guardian Authorization

By signing this form, I hereby waive and release Pope John Paul the Great Catholic High School, and its employees, from any and all liability for any injuries and illness incurred while my child is visiting the school. I know of no mental or physical condition which may affect my son/daughter's ability to safely participate in the Shadow Program at Pope John Paul the Great Catholic High School. If I cannot be contacted in an emergency, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment which a physician deems necessary for the well-being of my child.

- I **do** authorize John Paul the Great to photograph my child and I am aware that this picture may be displayed in the school or possibly used in school publications.

- I **do not** wish for photos of my child to be displayed or published in any way.

Parent/Guardian Name	Parent/Guardian Signature	Date
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Please email, mail or fax this completed and signed form to:

Pope John Paul the Great Catholic High School
Attn: Shadow Program
17700 Dominican Drive
Dumfries, VA 22026
Phone: (703) 445-0300
Fax: (703) 445-0301
admissions@jpthegreat.org

Soon after your completed form is received, a member from the Admissions department will contact you to confirm the date of your visit and provide you further information. Thank you for your interest in JP the Great!