

## FEMALE ENTREPRENEURSHIP PROGRAM

# Girls Mean Business

Girls Mean Business is a **free**, four-week program for girls aged 11-14 living in Antigonish who are interested in entrepreneurship.

The program will run on **Saturday, November 7th, 14th, 21st, and 28th** from 11:00am-12:00pm at St. Francis Xavier University in MSB, Room 225.

The girls will have the opportunity to develop products which they will sell at the Christmas Market in December. Additionally, they will learn how to make a business plan, and develop basic marketing and finance skills. The program will take place in-person and will respect social distancing protocols. Due to COVID-19, the program will be capped at 8 girls.

Sincerely,  
Grace Moffatt  
Program Developer, St. FX University

Kindly submit an email of intent by Friday, October 23rd, 2020 to Grace Moffatt at [gracemoffatt123@gmail.com](mailto:gracemoffatt123@gmail.com) or (709) 769-0300

# GIRLS MEAN BUSINESS Permission Slip/Emergency Form

No student will be allowed to participate without this form being completed and signed by the parent or guardian. The information on this form is considered confidential.

## Permission is granted for:

To participate in the Girls Mean Business Program on November 7<sup>th</sup>, 14<sup>th</sup>, 21<sup>st</sup>, 28<sup>th</sup>, 2020 located in Room 225, Mount Saint Bernard, St. Francis Xavier University.

## PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Emergency Phone #: \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_

Allergies: \_\_\_\_\_

Conditions requiring special consideration (medical/physical): \_\_\_\_\_

Does your student require: (A) **Epipen** Yes  No  (B) **Inhaler** Yes  No  (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration): \_\_\_\_\_

Primary contact name \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Cell Phone/Pager #: \_\_\_\_\_

I hereby authorize the release of my child's pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for my child, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for my child during this field trip.

## HEALTH INSURANCE INFORMATION:

Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

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

Parent/Guardian Signature: \_\_\_\_\_