Job Shadow Program Registration Form

You must be at least a high school junior to participate

Instructions: Please use **black** or **blue** **ink** when completing this form. *Fax the completed form to* ***(513) 803-6114.***

Name: _____
Last First Middle

Date of Birth: _____ **Phone:** ( ) _____ _____ _____
MM/DD/YYYY Home # Cell # Other

Home Address _____
Street City State Zip

School Currently Attending: _____

Current Grade Level (check one): ❒ **H.S. Junior** ❒ **H.S. Senior** ❒ **College** ❒ **Other**

E-mail Address: _____

(**REQUIRED** –Clearly indicate E-mail address, as this is our first point of contact with you)

Applications for the June, July, or August 2014 events are no longer being accepted

Application Timeline for the September 26, 2014 event:

1. *Registration Form will be posted the week of July 28th*
2. *Applications must be received by August 22, 2014.*
3. *Email notifications of placement opportunities will be sent out by September 10, 2014. (Requires a response)*

Comments: _____

The Job Shadow Program is limited to placement ONLY in the areas noted below. Please indicate up to two (2) health professions you are interested in shadowing. Indicate your preference order with a 1 or 2

☐	Dietician / Nutrition Therapist	☐	Radiology Technician {Ultrasound / X-Ray / MRI}
☐	Health Unit Coordinator (HUC)	☐	Respiratory Therapist
☐	Registered Nurse	☐	Social Worker (Must be a college student)
☐	Pharmacy	☐	Speech Pathologist
☐	Physician /Resident Team		
Areas not listed are not offered through this program			

☆ **For an experience in Audiology, please contact: Kelly.Baroch@cchmc.org**
☆ **For an experience in Occupational or Physical Therapy, please contact: Jan.Roth@cchmc.org**

Have you previously participated in the Cincinnati Children's Job Shadow Program? ☐ **Yes** ☐ **No**

Please be sure to complete the next page.

Cincinnati Children's Hospital Medical Center

Job Shadow Program Registration Form

Health Review

Medical History _____

Allergies _____

Current Medications_____

Impairments/Special Needs _____

Please read the following statements and check the box next to the statement if you agree.

☐ I / my child's immunizations are up-to-date.

☐ I / my child will only participate in the Job Shadow Program if free from infectious disease on the day of the program.

I give permission for my son/daughter, _____ to participate in a job shadowing experience at Cincinnati Children's Hospital Medical Center (CCHMC). I release CCHMC from all claims that may arise out of this observational experience. I understand this is an observational experience only and no patient care will be given by my son/daughter. My signature authorizes Cincinnati Children's Hospital Medical Center to act in an emergency, pending care, in case of illness/injury.

During the shadowing experience, I give consent for:

1. Treatment deemed necessary by the following physicians:
   a. Doctor _____ Phone Number _____
   b. Dentist _____ Phone Number _____
2. Treatment of the minor observer, if the above physicians cannot be reached.

Parent/Guardian Name (**print**) _____

Parent/Guardian Contact #'s : _____ _____ _____ _____

(Home) *(Work)* *(Cell)* *(Other)*

Parent/Guardian Signature (if minor) _____ Date_____

I, _____ (student), agree to behave in a responsible and professional manner during my job shadowing experience at Cincinnati Children's Hospital Medical Center. I understand that I am an observer only and will not be permitted to render care of any kind.

Student Signature_____ Date_____