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:** _____ _____ _____
(Month / Day / Year) 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)

Specify your 1st and 2nd choice by circling a date on each line. ***Please consider school calendars before indicating your preference.***

First Choice:	~~4/12/13~~ Filled	~~5/17/13~~ Filled	~~6/14/13~~ Filled	7/12/13	8/9/13	9/13/13	10/11/13	11/8/13	12/6/13
Second Choice:	~~4/12/13~~ Filled	~~5/17/13~~ Filled	~~6/14/13~~ Filled	7/12/13	8/9/13	9/13/13	10/11/13	11/8/13	12/6/13
➡ ***If we cannot accommodate your first or second choice, would you like us to continue to contact you if/when an opening becomes available? (Circle Yes or No)***								**Yes**	**No**

Comments: _____

NOTE: You will be contacted 1-2 weeks prior to a scheduled event when openings are available

Please indicate up to two (2) health professions you are interested in shadowing. We will do our best to accommodate you with your first preference. Indicate your preference order with a 1 or 2

- ☐ Audiologist
- ☐ Dietician / Nutrition Therapist
- ☐ Health Unit Coordinator (HUC)
- ☐ Registered Nurse
- ☐ Orthopedics
- ☐ Pharmacist
- ☐ Physician
- ☐ Radiology Technician {Ultrasound / X-Ray / MRI}
- ☐ Respiratory Therapist
- ☐ Social Worker (Must be a college student)
- ☐ Speech Pathologist

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.

Please Print

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 JSP 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_____

Please print