Job Shadow Program Registration Form

Instructions: *Please fax this completed form to* ***(513) 803-6114.*** *Thanks*

Name: _____
Last First Middle

Date of Birth: _____ **Phone numbers**: (H) _____ (C) _____
(Month / Day / Year)

Home Address _____
Street **City** **State** **Zip**

School Currently Attending: _____

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

E-mail Address: _____

Preferred Job Shadow Date: Please select a first, second, and third choice by circling a date on each line.

First Choice:	4/24/09	5/22/09	6/26/09	7/24/09	8/28/09	9/25/09	10/23/09	11/20/09	12/11/09
Second Choice:	4/24/09	5/22/09	6/26/09	7/24/09	8/28/09	9/25/09	10/23/09	11/20/09	12/11/09
Third Choice:	4/24/09	5/22/09	6/26/09	7/24/09	8/28/09	9/25/09	10/23/09	11/20/09	12/11/09

Please indicate up to three (3) health professions you are interested in shadowing.
Indicate your preference order by 1, 2, or 3.

- ☐ Audiologist
- ☐ Laboratory Scientist
- ☐ Registered Nurse
- ☐ Nutrition Therapist (Registered Dietitian)
- ☐ Orthopedics
- ☐ Occupational Therapist
- ☐ Pharmacist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Radiology Technician
  - ☐ Ultrasound
  - ☐ X-Ray / MRI
- ☐ Respiratory Therapist
- ☐ Social Worker
- ☐ Speech Pathologist

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

Please be sure to complete the next page.

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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_____