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 (if student is under 18 must have parent permission).

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_____