Job Shadow Program Registration Form

You must be at least a high school junior and 16 years of age to participate

Instructions: *Use* **black** or **blue** **ink** when completing this form. *Fax the completed form to* ***(513) 636-8893.***

Name: _____
Last First Middle

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

Home Address _____
Street City State Zip

Ethnicity: ❒ African American ❒ Latin American ❒ Caucasian ❒ Asian ❒ Other_____

Gender: ❒ Male ❒ Female ❒ Other

_____ _____
Primary Language Secondary Language

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

Job Shadow is a 5 hour experience from 7am -12 pm only. Event is limited to 20.

When the 20-person capacity is reached, the application will be removed from the website.

PLEASE NOTE THE FOLLOWING:

- *Email notifications of placement opportunities will be sent out 7-10 days in advance of an event* ***ONLY*** *when openings are available. Your response (R.S.V.P.) will be required.*
- *Please re-apply for a later event if you do not receive notification of an opening for the current month.*

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**

☐	Audiology	☐	Radiology Technician (Ultrasound / X-Ray / MRI)
☐	Physician/residency team	☐	Respiratory Therapist
☐	Social Worker (High School graduate; 18 years	☐	Speech Pathologist
☐	Registered Nurse	☐	Pharmacy

Areas not listed are not offered through this program

☆

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

Please be sure to complete the next page.

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.

☐ Attached evidence of flu vaccine between Nov 1 and March 31

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_____