

## OTPT Job Shadow Program Registration Form You must be at least a high school junior and 16 years of age to participate

Last					
			First		Middle
Date of Birth:	Phone:				_
	MM/DD/YYYY		Home #	Cell #	Other #
lome Address					
		Street	City		State Zip
Gender: 🗖 N	∕lale □ Fema	le			
				Seco	ndary Language
chool Currently	Attending:				
Current Grade Le	evel (check one):	☐ H.S. Junior	☐ H.S. Senior	☐ College	☐ Other
-mail Address:					
mergency Contact Jame/Number:					
Have you previo	ously participate	d in the Cincinnati C	Children's Job Shadov	v Program?	Yes No
Health Review					
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Medical History					
Medical History					
Medical History Illergies Current Medication	ns				
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I give permission for my son/daughter,	to participate in a job shadowing
experience at Cincinnati Children's Hospital Medical Center (CCHMC). I releas	se CCHMC from all claims that may arise out of this
observational experience. I understand this is an observational experience or	nly and no patient care will be given by my
son/daughter. My signature authorizes Cincinnati Children's Hospital Medica	l Center to act in an emergency, pending care, in case
of illness/injury.	
Parent/Guardian Signature (if minor)	Date
I, (student), agree to behave job shadowing experience at Cincinnati Children's Hospital Medical Center. It permitted to render care of any kind.	
Student Signature	Date

Please remember to attach documentation proving that the observer has received a flu vaccine at least two weeks prior to the observation experience if the observation experience is between the months of October and March.

A photo of the paper will be acceptable.