

Job Shadowing Liability Release Agreement

| is scheduled to participate in a Job Shadow experience at a PINISI f | acility. | |
|---|----------------|--|
| I understand that job shadowing is an observation experience. I will be assigned to an office who lead me through the activity. They will discuss a typical workday, explore different aspects of work the healthcare setting, and identify the skills that are needed in the working world. While on PMS premises, I will abide by all the policies, rules and regulations of PMSI and follow all directions give | rking in SI | |
| Liability Release | | |
| I release PMSI, it's employees and volunteer staff from any claim or liability arising from my participation in Job Shadowing activities. | | |
| Photo Release | | |
| I understand that there is a possibility that students may be photographed during their experience help promote the program. I grant permission to be photographed for this purpose. | e to | |
| Authorization for Medical Treatment | | |
| I hereby authorize PMSI to provide emergency or urgent medical treatment as deemed advisable by any physician or surgeon on the PMSI Professional Staff. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care required, and that PMSI will rely on this authorization only in the event of an emergency or urgent situation. In the case of a minor student, every effort will be made to contact the parent/guardian listed prior to treatment, and the consent will be only used at a time when the parent/guardian consent may not be available. | | |
| I verify that the student is a high school senior and is 17 years of age or older. | | |
| Signature of Shadowing participant: Date: | | |
| Signature of Parent/Guardian (REQUIRED FOR HIGH SCHOOL STUDENTS 18 YEARS OR YOUNGER) As a parent/guardian of the above-named person, I understand that this Waiver of Liability Agree (waiver) must be signed by me in order for my child to participate. | ment | |
| Parent/Guardian Signature: Date: | | |
| Printed Name: Phone: | | |

PARENTAL CONSENT FOR MINOR TO PARTICIPATE IN SHADOWING PROGRAM

| Student Name: | <u>-</u> |
|---|----------|
| Dates of participation: | |
| I confirm that I am the parent/guardian of this student of participation, waiver of liability and consent for the | |
| Parent/Guardian Signature: | Date: |
| Printed Name: | |