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.**

Applications are accepted ONLY DURING OPEN REGISTRATION.

Name: _____ Last	First	Middle
Date of Birth: _____ MM/DD/YYY	Phone: _____ Home	_____ Cell
Home Address: _____ Street	City	State Zip
Gender: (check one) Male ____ Female____	Ethnicity: (check one) African American __ Latin American __ Caucasian __ Asian __ Other __	
Primary Language:	Secondary Language:	
_____ School Currently Attending	Current Grade: (check one) H.S. Junior __ H.S. Senior __ College __ Other __	
Email Address: Required- Clearly PRINT email address as this is our first point of contact with you.		

Job Shadowing is a 5 hour experience (7 am to 12 pm only) held once a month April through December on the dates assigned on the website.

This event is limited to 20 participants per month

When the 20-person capacity is reached, the application will be removed from the website. No applications will be accepted until the following enrollment period.

PLEASE NOTE THE FOLLOWING:

- Email notifications of placement opportunities will be sent out 7 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.

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 by circling a 1 or 2

1	2	**Audiology**	1	2	**Radiology Technician**
1	2	**Registered Nurse**	1	2	**Speech Pathologist**
1	2	**Pharmacy**	1	2	**Physician/Resident Team**

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.

Please check the website periodically for changes or updates

http://www.cincinnatichildrens.org/education/community/job-shadow/default/

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 (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:

Doctor:	Phone:
Dentist:	Phone:

2. Treatment of the minor observer, if the above physicians cannot be reached.

Parent/Guardian Name (Print):	Parent/Guardian Signature (if minor):	
Home Phone:	Work Phone:	Cell Phone:

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:

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