Cabell Huntington Hospital	**PARENTAL CONSENT FOR JOB SHADOWING**

My son/daughter,_____ (please print), has my permission to participate in Job Shadowing at Cabell Huntington Hospital. As the parent/guardian of the above-named student, I will read the information that is provided to my child so that I know what will be expected of him/her.

I confirm that my child is at least 14 years of age, is free from communicable diseases and will be able to provide evidence of negative TB screening and proof of immunization (signed by licensed nurse or healthcare provider), immunity by laboratory results (positive titre), or natural disease history (diagnosed, documented, and signed by licensed healthcare provider) of rubella (German measles), rubeola (measles), and varicella (chicken pox) within 24 hours of request by hospital personnel.

Job Shadowing may include observing patients in a healthcare setting and observing medical, laboratory, and/or business procedures. I further understand that Cabell Huntington Hospital offers medical services for the care and treatment of a wide range of illnesses, diseases and injuries, including but not limited to, such infectious diseases as tuberculosis, hepatitis, and HIV and there is a risk, however slight, that my son/daughter might be inadvertently exposed to such diseases at the Hospital.

I further understand that my son/daughter may become aware of private or confidential information about patients during Job Shadowing and he/she will be required to comply with the requirements of the Confidentiality Agreement that we will need to sign separately.

I hereby release Cabell Huntington Hospital, its employees and staff from any responsibilities for any injury, accident or illness as a result of my son's/daughter's participation in Job Shadowing at Cabell Huntington Hospital. Any medical expenses incurred as a result of such injury, accident or illness will be my responsibility.

I understand that in case of a medical emergency, every attempt will be made to contact me before care is provided. However, this document is my consent as parent or guardian for emergency treatment and/or procedures necessary for my son/daughter by the employees and staff at Cabell Huntington Hospital.

_____

Signature of Parent/Guardian Date

Contact Information (please print):

Name: _____

Telephone Nos: _____