



Job Shadowing Liability Release Agreement

_____ is scheduled to participate in a Job Shadow experience at a PMSI facility.

I understand that job shadowing is an observation experience. I will be assigned to an office who will lead me through the activity. They will discuss a typical workday, explore different aspects of working in the healthcare setting, and identify the skills that are needed in the working world. While on PMSI premises, I will abide by all the policies, rules and regulations of PMSI and follow all directions given me.

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 to help promote the program. I grant permission to be photographed for this purpose.

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 Agreement (waiver) must be signed by me in order for my child to participate.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Phone: _____

PARENTAL CONSENT FOR MINOR TO PARTICIPATE IN SHADOWING PROGRAM

Student Name: _____

Dates of participation: _____

I confirm that I am the parent/guardian of this student and have read the program requirements, details of participation, waiver of liability and consent for them to participate in the PMSI shadowing program.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____