COMMUNITY HOSPITAL ANDERSON
HEALTH CAREER

Documentation of Observational Experience

Observer's Name: ____

Observer's Phone Number: ____

Purpose of Observation Experience: ____

I. PERMISSION:

I, ____ (student's parent or guardian), hereby give my permission for ________________________________ (observer participant; hereinafter "Student") to participate in the observation. I understand that participation will allow the Student to "shadow" employees within the hospital(s) and/or off site departments. This experience is designed to be observational though may involve exposure to health risks such as contact with patients and body fluids.

In consideration for participation of the Student in the program and the education and information which the Student will receive, I hereby release, indemnify, and hold harmless Community Hospital Anderson, its employees, officers, and agents from any and all liability arising out of or resulting from the Student's participation.

___________________________________ ______________________________ ______________

Signatures: Parent or Legal Guardian of Student (If observer is not emancipated) | Observer | Date

II. HEALTH REQUIREMENTS:

The school has on file a copy of the student's health record that includes the following or observer provides documentation of the following:

__________ Natural history of proof of immunization for Mumps, Rubella, and Rubeola

SIGNATURE OF STUDENT ____ DATE ____________________

SIGNATURE OF PARENT ____ DATE ____________________