BUTLER COUNTY HEALTH

Job Shadowing Agreement & Release Form

I, (Student) _____, wish to participate in the job shadow program at Butler County Health.

As a job shadowing program participant, I understand that I am not to be involved in the providing of patient care or in a patient care area without my assigned sponsor or his/her representative being present and if I breach this agreement, it may result in immediate termination of my job shadow assignment.

- I understand that even though I will only be observing, I may be exposed to certain risk of bodily injury or other dangers, including but not limited to, exposure to blood borne pathogens, biological waste, and dangerous chemicals, and I assume these risks.

- I hereby release and forever discharge Butler County Health and its officers and employees from all claims, demands, rights and causes of action of whatever kind or nature arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, death, or damage to property arising out of my observation activities, including but not limited to, those specified risks itemized above.

- I agree to conduct myself in a courteous and respectful manner to patients, visitors and staff while student shadowing at Butler County Health.

- I agree to follow the dress code guidelines at Butler County Health.

- I understand and take sole responsibility for any personal belongings I bring with me to Butler County Health.

- I authorize the staff at Butler County Health to provide medical treatment in the case of an emergency.

I have read this document carefully and I voluntarily choose to participate in the activities described herein.

_____

Student Name Printed | Student Signature | Date

_____

Parent or Guardian Name Printed | Parent or Guardian Signature Required if Student is not 19 years of age | Date