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 _____