**COLLEGE STUDENT/PROFESSIONALS**

 **OBSERVATION AGREEMENT**

**FOR**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Student Name)**

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 **(College/University/Work Affiliation Name)**

* I am currently not ill and have not recently been exposed to chicken pox, measles, or other contagious diseases.
* I understand that I must present myself in a professional manner and attire while at Nationwide Children’s Hospital. I must comply with Nationwide Children’s Hospital’s dress codes, policies and Standards of Conduct and if I do present myself for the observation experience dressed in violation of the dress code that I may be asked to withdraw from the observation program.
* I, the undersigned, understand that all **patient information is confidential** and agree not to reveal any patients’ names or discuss information about their condition with other patients, families, peers, or others.
* Due to patient confidentiality, students participating in a Nationwide Children’s Hospital observation experience may not take photographs while on campus.
* I understand that while precautions will be taken, the student may be exposed to a variety of communicable diseases during the experience. Nationwide Children’s Hospital will not be held liable for illness or injury resulting from the experience.
* I agree to adhere to Nationwide Children’s Hospital’s dress and appearance guidelines.

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**Student Signature Date**

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**Address (please include county)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Unit/Department**

**Observation Student**

**Health Release Form**

**Health Screening**

Are your immunizations up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you received the seasonal flu vaccination?\*\* \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you received the H1N1 flu vaccination?\*\* \_\_\_\_\_ Yes \_\_\_\_\_ No

**\*\*Please note that if you are not up to date on your yearly seasonal flu vaccination, you will NOT be able to shadow!\*\***

**Have you have been exposed to any of the following communicable diseases within the past month?**

\*Chicken Pox \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Measles \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Mumps \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Pertusis \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Tuberculosis \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Other \_\_\_\_\_ Yes \_\_\_\_\_ No (if yes, please explain)

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**Have you had any of the following symptoms within the last 48 hours? (This section to be completed two days before your visit)**

\*Respiratory infection runny nose, cold sore throat \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Cough \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Fever \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Diarrhea/Vomiting \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Rash \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Lice \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Pink eye \_\_\_\_\_ Yes \_\_\_\_\_ No

**Emergency Consent:**

I, the undersigned, hereby consent to the Nationwide Children’s Hospital or any of its staff or agents, to provide any emergency treatment deemed necessary for my benefit if injured or become ill.

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Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Please return forms to: Keyla Fincher, Education**

**700 Children’s Drive, Columbus, Ohio 43205**

**\*\*Please note that if you are not up to date on your yearly seasonal flu vaccination, you will NOT be able to shadow!\*\***

# IMPORTANT!!!

During your visit to Nationwide Children's Hospital we want to remind you of a few **IMPORTANT** items:

1. **Please be certain to have your Parent/Guardian sign the Observation Agreement and Health Release form document** along with you if you are under the age of 18, and return it on the day you come in, or you can mail it back prior to your visit. Without this document, you will **not** be able to shadow.
2. On the day of your shadowing experience, please remember to have a professional appearance consistent with the hospital dress and appearance guidelines.
	* Clothing is to be professional looking, fit appropriately and be in good condition
	* Shorts, gym shoes, sandals (open-toed), jeans, tank tops, skirts above the knee and cut-off tops are **prohibited**
	* Body piercing (except ears) and tattoos she be limited and/or covered

Without proper clothing, you will **not** be permitted to shadow.

School uniforms and scrubs are acceptable.

1. Proper Identification (will be provided). This badge needs to be visible and worn at all times.

# Student Evaluation Form

Please complete this brief evaluation of your shadow experience today so that we can continue to improve student relations.

Rate the following on a scale of one to six (**one** indicates that you strongly disagree with the statement and **six** that you strongly agree.)

### Statement Strongly Strongly

 **Disagree Agree**

My career observation experience helped 1 2 3 4 5 6

me to think about career options.

I learned what the general expectations are for 1 2 3 4 5 6

employees at the site.

I enjoyed my workplace experience. 1 2 3 4 5 6

I would recommend Children’s for other 1 2 3 4 5 6

students to do Shadow experiences.

**For successful shadow experiences in the future, Nationwide Children’s should:**

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**Any additional comments?**

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**Please return to:**

Cary Woodard, Community Education Department

700 Children’s Drive, Columbus, Ohio 43205

Or fax to: 614.355.0670