LakeShore Health Care Alliance

Strengthening the health care workforce in Manitowoc and Sheboygan Counties

Lakeshore Health Care Alliance
High School Job Shadowing Application and Confidentiality Agreement

Participant's Name ____ Grade____________

Email Address: ________________________________ Phone Number______________________

School____ School Representative____________________

Representative's Phone Number ____________________ Fax ________________ Email ______________

Position Requesting to Shadow____

Please advise us of any physical limitations that need to be accommodated: ____________________________

"Career Experience" Attended: ________________________________ Date: ______________________
(Only needed for HS students)
(Name of health care or academic facility) **(required information)**

Date Job Shadow needs to be completed ____________________ Number of requested hours ______________

Please make an X on the dates and times you are available to complete a Job Shadow

Time & Date	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8AM- Noon						
Noon- 5PM						

JOB SHADOWING/CONFIDENTIALITY AGREEMENT

I have read the *Job Shadow Information Sheet* prior to my job shadowing experience and have had all of my questions about the information answered. I agree to abide by the rules identified in the information and keep all patient information confidential.

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Student Signature Date

I have read and understand the information on the *Job Shadow Information Sheet*, and authorize my son/daughter to participate in this job shadowing experience. Should my son/daughter need medical attention during or as a result of this job shadowing experience, I assume full responsibility for any treatment deemed necessary.

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Parent/Guardian Signature (Relationship) (If student is not 18 years of age) Date

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EMERGENCY Contact Name: Home/Cell Phone: Work Phone:

I have reviewed the above information with the student and verify that the required immunizations are on record.

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School Representative Signature/Title Date