Memorial Healthcare

High School Job Shadowing Application - less than 16 hours

Student Information (please print)

Name: ______________________ Student Phone number: ______________

Address: ____

City: ______________________ State: ________ Zip: ______________

Age: ________ (mim. Age 16) Date of Birth: ________

School: ______________________________ Grade: ______________

Student or Parent email address: ______________________________

Select top 3 choices and number (1, 2, 3) in order of your preference.

________ Nursing
________ Physical Therapy
________ Computers
________ Pharmacy
________ Radiology
________ Speech therapy
________ Respiratory therapy
________ Laboratory
________ Social Work
________ Physician Assistant/Medical Assistant/Nurse Pract.

Please describe your interests in healthcare, your post-high school plans, and why you want to job shadow.

Immunizations

Please list dates below and enclose proof of immunizations

Varicella (Chicken Pox)
1st: ________
2nd: ________

MMR (Measles, Mumps & Rubella)
1st: ________
2nd: ________

Influenza (Flu shot)
Required Every year by Nov. 1
Date: ________

Covid vaccine is not required because of the limited hours of the job shadow experience. If more than 16 hours is required, please contact Volunteer Services.

TB Screening

________ Proof of negative TB test within the past year

OR

Complete the following (Please check YES or NO to the following questions);

In the past year, have you had:

a. Unaccountable weight loss ________ Yes ________ No
b. Onset of chronic cough ________ Yes ________ No
c. Coughing up of blood ________ Yes ________ No
d. Chest pain on breathing ________ Yes ________ No
e. Night sweats ________ Yes ________ No
f. Unaccountable fever ________ Yes ________ No
g. A chest x-ray ________ Yes ________ No

If you answer YES to any of the questions above, please give an explanation below:

Name: ______________________________ Student Phone number ____________________

Parent/Guardian Permission

I give permission for my child ______________________________________, (a minor) to participate in an observational experience at Memorial Healthcare. I release Memoiral Healthcare from all claims that may arise from this observational experience. I understand this is an observational experience only and there will be no patient care given by my child.

______________________________ ______________________________
Parent/Guardian Name (Printed) Parent /Guardian (Signature)

______________________________ ______________________________
Date Phone number that we can reach you during the job shadow experience.

The following forms must be sent with this application

__________ Job Shadow Agreement
__________ Confidentiality Agreement
__________ Proof of Immunizations
__________ Copy of Driver's license (age 18 and older)

Email completed forms to: tcoffman@memorialhealthcare.org

Applicants with missing forms or incomplete forms will not be able to job shadow. All job shadow experiences are assigned in the order in which they are received.

We will contact you via email with the assigned observation date.