Memorial Healthcare
High School Job Shadowing Application

Student Information (please print)

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ 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	_____ Speech therapy
_____ Physical Therapy	_____ Respiratory therapy
_____ Computers	_____ Laboratory
_____ Pharmacy	_____ Social Work
_____ Radiology	

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

What date(s) would you like to observe? (exact dates coming soon)

_____ Oct. 18 2018	_____ Jan. 10 2019	_____ Apr. 11 2019
_____ Nov. 15 2018	_____ Feb. 14 2019	_____ Summer 2019
_____ Dec. 13 2018	_____ Mar. 14 2019	

Immunizations

Please list dates below and enclose proof of immunizations

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

Tuberculin (TB/PPD)
Required EVERY year
Date: _____

MMR (Meases, Mumps & Rubella)
1st: _____
2nd: _____

Tdap (Tetanus, Diptheria, Pertussis)
Date must be within last 10 years:
Date: _____

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

Hepatitis B
1st: _____
2nd: _____
3rd: _____

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

Home/Cell Number

Teacher/Counselor Information

Completed by teacher/counselor

Please enter student information and sign and date this section. The signature constitutes school approval to release the student to participate in this experience. **This is not required during summer.**

Teacher/Counselor Name (Printed)

Phone Number

Email address

Teacher/Counselor (Signature)

Date

The following forms must be sent with this application

_____ Job Shadow Agreement
_____ Commitment Statement
_____ Confidentiality Agreement
_____ Proof of Immunizations

Mail or Email Completed forms to:

Cindy George
Education Department
Memorial Healthcare
826 W. King St
Owosso, MI 48867

OR

cgeorge@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.