Children's Hospital Central California

JOB SHADOW INFORMATION SHEET

NAME:_____ DATE:_____

ADDRESS:_____ PHONE:_____
STREET

_____ _____ _____
CITY STATE ZIP CODE

ARE 18 YEARS OF AGE OR OLDER? ❑ YES ☐ NO

REASON FOR JOB SHADOW:_____

_____

_____

_____

SCHOOL/COMPANY AFFILIATION:_____

FOR HOSPITAL USE ONLY

❑ CONFIDENTIALITY AGREEMENT DATE:_____

❑ HEALTH QUESTIONNAIRE

❑ CONSENT FORM FOR MINORS (IF APPLICABLE)

❑ BADGE ISSUED

EMPLOYEE:_____ **TITLE:**_____

DEPARTMENT:_____ **EXTENSION/PAGER:**_____

TIME OUT:_____ **TIME IN:**_____ **TOTAL HOURS SHADOWED:**_____ ❑ **BADGE COLLECTED**

ADDITIONAL COMMENTS:

Children's Hospital Central California

JOB SHADOW

CONSENT FORM FOR MINORS

I understand that my child, _____, (a minor) is participating in the Job Shadow program at Children's Hospital Central California. I also understand that my child has requirements/responsibilities within this program, of which he/she is aware, and that failure to comply with these requirements/responsibilities may result in dismissal from the program.

NOTE: This form must be signed by the parent/guardian and returned to the Volunteer Services Department before the minor is permitted to participate in the noted program.

_____ _____
Job Shadow Participant Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Volunteer Coordinator Signature Date

IF YOU ARE **UNDER** THE AGE OF 18, PLEASE HAVE YOUR PARENT OR LEGAL GUARDIAN COMPLETE THIS FORM.

IF YOU ARE **OVER** THE AGE OF 18, PLEASE DISREGARD THIS FORM AND DO NOT SUBMIT IT WITH THE REST OF YOUR PAPERWORK

Children's Hospital Central California

JOB SHADOW
HEALTH QUESTIONNAIRE

NAME:_____ BIRTHDATE:_____

EMERGENCY CONTACT PERSON:_____

RELATIONSHIP:_____ PHONE:_____

Please answer the following the questions.

1) In the past 24 hours, have you had any of the following (check all that apply):

❑ Vomiting ❑ Cold ❑ Cough ❑ Rash ❑ Fever ❑ Diarrhea ❑ Runny Nose ❑ None

2) In the past three weeks, have you been exposed to anyone with the following (check all that apply):

❑ Measles ❑ Mumps ❑ Varicella (Chicken Pox) ❑ No exposure

3) Have you been exposed to Tuberculosis (TB) in the last three months? ❑ Yes ❑ No

4) How would you describe your overall health? ❑ Excellent ❑Good ❑ Fair ❑ Poor

5) If you are sensitive to a hospital environment for some reason (i.e. past hospitalization or traumatic experience) or are prone to seizures or fainting, please indicate that below:_____

_____

_____

_____

_____

_____

_____

I certify the information given regarding my health to be accurate and to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Parent or Legal Guardian signature (for those under 18 years of age) Date

Effective: 11/2007

Children's Hospital Central California

CONFIDENTIALITY AGREEMENT FOR NON-EMPLOYEES

I, the undersigned, acknowledge that during the course of my voluntary participation or performance of duties at Children's Hospital Central California that I may receive access to confidential information of Children's that is prohibited from disclosure to others.

"Confidential Information" means information provided by Children's that is not commonly available to the general public, or is required by law or regulation to be protected from disclosure to third parties not considered part of the Hospital's "workforce" as that term is defined by federal and state health information privacy regulations such as the Health Information Portability and Accountability Act and the California Confidentiality of Medical Information Act. Confidential Information includes information contained in patient medical records and any other health information which identifies a patient; quality assurance, research or peer review information; and information concerning Children's employees, services or business operations. Such information can be acquired by any means and in any form, written, spoken or electronic.

I agree not to share, disclose or discuss Confidential Information with anyone who does not have a legitimate interest in such information. I will abide by Children's policies and procedures concerning the use or disclosure of Confidential Information and I will contact a Children's representative if I have any questions regarding these policies and procedures.

I will maintain and protect the privacy of Children's employees, medical staff and patients in my use and disclosure of Confidential Information and I will not misuse or be careless with such information.

I understand that any violation of this Agreement or Children's policies related to access, use or disclosure of Confidential Information may result in significant legal ramifications for which I will be held solely responsible with respect to this Agreement.

I acknowledge that I have reviewed all of the information above. I understand that compliance with the principles, policies and procedures expressed above is a condition of my participation and continued presence at Children's Hospital Central California.

_____ _____

Name (please print) Date

_____

Signature

CHILDREN'S HOSPITAL CENTRAL CALIFORNIA
VOLUNTEER SERVICES

JOB SHADOW PARTICIPANT
DRESS CODE

As part of the Job Shadow Program, your appearrance is important. Your clothing should be neat, tidy and clean. A few things to remember:

- No jeans
- No sweatpants
- No tank tops or bare midriffs
- No baggy clothes or clothes that drag the floor
- No exposed undergarments
- No scrubs

Please wear comfortable closed toe shoes, clean gym shoes are acceptable. Socks or stockings must be worn.

- No sandals
- No flip flops
- No dangling jewelry
- All body piercing and tattoos must be covered