UNIVERSITY MEDICAL CENTER, INC.

University of Louisville Hospital / James Graham Brown Cancer Center

Volunteer/Job Shadow Parent Consent and Release of Liability Form

If volunteer/shadower is under of the age of 18, parental guardian consent is required.
My son/daughter, _____, has my permission to serve as a University Medical Center Teen Volunteer and/or participate in the University Medical Center Job Shadow experience. As the parent/guardian of the above-named student, I will read the literature that is provided to my child so that I know what will be expected of him/her.

I attest that my child meets the age requirement for the Volunteer Program (location specific) or is 16 years of age (Job Shadower Program). I attest my child is free from communicable diseases and will be able to provide evidence of negative TB screening and proof of immunization (signed by licensed nurse or healthcare provider), immunity by laboratory results (positive titre), or natural disease history (diagnosed, documented, and signed by licensed healthcare provider) of rubella (German measles), rubeola (measles), and varicella (chicken pox) within 24 hours of request by hospital personnel.

Volunteering and/or Job Shadowing may include observing patients in a healthcare setting and observing medical, laboratory, and/or business procedures. I further understand that University Medical Center offers medical services for the care and treatment of a wide range of illnesses, diseases and injuries, including but not limited to, such infectious diseases as tuberculosis, hepatitis, and HIV and that there is a risk, however slight, that my son/daughter might be inadvertently exposed to such diseases at the Hospital.

I do hereby release University Medical Center, their staff and sponsors from any responsibilities of injury or accident as a result of the volunteering/shadowing experience. Any medical expenses incurred as result of injury or accident will be my responsibility.

I understand that in case of a medical emergency, every attempt will be made to contact me before medical action is taken. However, this document is my consent as parent or guardian for emergency treatment and/or procedures necessary for my son/daughter by the professional staff at University Medical Center.

I release, discharge and relieve University Medical Center from any and all claims whatsoever of any nature as a result of his/her volunteering/shadowing and all related activities.

_____

Parent/Guardian Signature

_____

Date