Parental/Guardian Permission

Authorization is required for all students under 18 years of age

I, the undersigned, give my child, _____, permission to shadow at Bryan Medical Center. I understand that my child has requested a shadow experience at Bryan. I understand that my child will be under strict obligations of confidentiality concerning any matters of patient care observed at the assigned shadow site. I also understand that my child will not be allowed to administer any level of patient care. This opportunity is one strictly of observation. I understand that I will be contacted if any emergency arises. S/he will follow the direction of the physician or Bryan staff for the duration of the shadow experience.

I understand and will help my child understand, that confidentiality is absolutely necessary. I understand that my child will need to leave their cell phone at home, in their car or with the charge nurse on the floor. All information will be held in strict confidence and not released for any reason outside of Bryan Medical Center. No reference is to be made as to the identity, diagnosis or treatment of a patient. Questions about the shadowing experience should be directed to the physician or employee my child worked with.

Parent/guardian signature_____Date_____

Print parent/guardian name_____

Print name of student shadowing_____

Parent/Guardian contact information:

Address_____Phone:_____