



University of Connecticut Health Center

Form F Parent Permission Form for A Non Paid Observational/Internship School Sponsored Student Educational Experience 2009-2010

To Be Completed By A Parent Or Legal Guardian (If student is 15 or older, but less than 18 years of age)

In accordance with the University of Connecticut Health Center's policy statement Minors in the Workplace, we must obtain a written informed parental consent from a parent or legal guardian of a minor student who is under 18 years of age and wants to have a student observational/affiliation experience at the University of Connecticut Health Center (UCHC).

I grant permission for my son/daughter (**Print Full Name**) _____ to participate in a Student Observational/Internship Experience. To the best of my knowledge, he/she is in good health and is able to participate in this endeavor with the following physical limitations:

_____.

I understand that there are potential risks, including but not limited to exposure to lab activities, human materials and radioactive materials.

I also understand that the following controls will be taken to minimize risks: Safety Training, Supervision by Host/Preceptor/Manager, Use of Appropriate Protective Equipment

In consideration for (name of son/daughter) _____'s participation in the above-stated Student Observational/Internship Experience, I hereby release, waive, discharge, and covenant not to sue the State of Connecticut, the University of Connecticut, the University of Connecticut Health Center, and its/ their officers, employees, and agents for liability from any and all claims including the negligence, of its officers, employees and agents, resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, my son/daughter's participation in said program.

I agree to HOLD HARMLESS the State of Connecticut, the University of Connecticut, the University of Connecticut Health Center and its/ their officers, employees, and agents from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of _____'s participation in the above-stated Student Observational/Internship Experience.

Son/daughter

I understand that the University of Connecticut Health Center conducts background checks on all individuals, regardless of age, participating in non-paid educational experiences on site. I grant my permission to have this background check done on my son/daughter.

Additionally, the University of Connecticut Health Center is given permission to reproduce for publications any photos taken of my child during his/her participation in the Student Observational/Affiliation Experience, and said photos shall be the property of the University of Connecticut Health Center.

Signature of Parent or Legal Guardian

Date

Name of parent or legal guardian: _____
Home Telephone Number: _____ Cell Phone #: _____

Work Telephone Number: (Mother) _____ (Father) _____
Family Physician: _____ Telephone Number: _____
Person to notify in case of emergency: _____
Telephone/Cell Phone Number: _____ Relationship: _____

The University of Connecticut Health Center requires that all minors (those 15 or older but less than 18 years of age) must have on file "Consent for Treatment" form, signed by a parent or legal guardian before the applicant can be accepted in an Observational/Affiliation Experience Program and begin his/her assignment at John Dempsey Hospital/ University of Connecticut Health Center.

This is a preventive measure in case of illness or injury of a minor while participating in the program, and would be used only if reasonable attempts to reach the parent or guardian have been made.

CONSENT FOR TREATMENT

In the event _____ required medical and/or surgical
(Name of Observational/Intern Participant)
treatment while participating in an Student Observational/Internship Experience at the University of Connecticut Health Center, I, the undersigned, hereby give my consent for any medical and/or surgical treatment as the attending physician and/or surgeon deems necessary. This includes the giving of anesthetics.

I have read the above and understand it, and grant permission.

Signature, Parent or Legal Guardian

Relationship

Revised: 4/09

Host/Preceptor/Manager place copy in student file, send original to Office of Research Safety MC3930