Parental Consent and Release

My child (please print full name) ________________________________ has my permission to attend Apollo: Youth in Medicine Information Session/Physician Shadowing to be held at the Medical Society of Delaware and Physician's office in the months of months and year.

I hereby give my permission for my child to attend said event and I understand that my child will be chaperoned by responsible adults. I understand that Apollo: Youth in Medicine events are conducted in smoke-, alcohol-, and drug-free environments. In light of this, and to help ensure the safety of all concerned, I understand that if my child is in possession of drugs, alcohol, or tobacco products, engages in illegal, immoral, or offensive behaviors, or refuses to follow the directions given by Apollo: Youth in Medicine volunteers while participating in this activity, I will be contacted immediately to pick up my child. As parent/guardian, I understand that promotional pictures (individual and group) may be taken during this event. I give permission for my son's/daughter's picture to be used for promotional materials (newsletter, web page, power point, etc.) in highlighting the event. By my signing this, I release Apollo: Youth in Medicine from any and all liabilities and waive all claims against them. I also give my permission for the event coordinator to obtain proper medical treatment for my child should it become necessary.

Insurance Carrier/Policy Number/Group Number ____

Insurance Subscriber ____

Insurance company address ____

Insurance company phone number____

Date of Birth ____

Prescription meds taken regularly* ____

Other medication taken regularly ____

Emergency Contact Name/Number ____

Electronic/mobile communication affords the event coordinators the best means of providing reminders and updates to participants. Please provide an email address and/or cell phone number for such communication purposes.

Home Address ____

E-mail address _______________________________________ Cell Number ________________________________

In case of emergency, please contact me by phone at ____

If necessary, the group leader is permitted to administer the following over the counter medications to my child:

Advil Tylenol Motrin Aleve Halls (cough drops)

Claritin/Zytrec Benadryl Robitussin (cough syrup)

Other (please specify) _____________________________________

**If Prescription Medication is indicated, please attach a list of the medicine and dosage*

Signature of Parent/Guardian: ____

Relationship to Participant:____ Date: ______________

NOTE: NO STUDENT WILL BE INCLUDED WITHOUT THE SUBMISSION OF THIS FORM PRIOR TO THE EVENT.

PARTICIPATION AGREEMENT

Apollo – Youth in Medicine Student Observation Program

Congratulations and welcome to the Apollo – Youth in Medicine program.

On behalf of Apollo and our volunteers, we are pleased to offer you the opportunity to shadow one of our volunteer Medical Society of Delaware physicians and their team. You will receive information on your doctor separately and you can then contact that office to make the necessary arrangements. Please review, sign & return this Participation Agreement.

During this observation opportunity, either you or the volunteer physician may discontinue this privilege at any time, and for any reason not prohibited by law. In addition, there is no guarantee of continued or advanced employment associated with this privilege. Your time spent shadowing & observing will not be considered time worked as an employee; therefore, you will not receive a salary, wage, benefits or any other employment related compensation for time spent shadowing.

During your observation time, you may become aware of confidential patient health information and business information. By participating in this opportunity, you acknowledge that you must and will adhere to the doctor/practice confidentiality policies. In addition, when the time of shadowing concludes, you must return any practice property, equipment, and documents, including electronic mail or other information given to you in conjunction with this process.

If you have any questions about the terms of this observation opportunity, please contact us directly. We are very excited about the prospect of helping you to enhance your education.

My signature (with my Guardian's signature) below indicates my acceptance of the offer as outlined above.

Signed,

____

Name of Individual Shadowing/Observing (print & signature)

____

Email Cell phone Date

____

Parent or Guardian (If individual shadowing is under Age 18) (print & signature)

____

Email Cell phone Date