HEALTH CAREER ACADEMY

SENIOR INTERNSHIP

HEALTH CLEARANCE/PARENT/GUARDIAN CONSENT PACK

**Liberty High School**

**850 Second Street, Brentwood, CA 94513**

**Telephone (925) 634-3521**

**A-wing FAX (925) 513-2739 B-wing FAX (925) 516-2581**

**Principal’s Office FAX (925) 240-0735**

**Patrick M. Walsh, Principal**

 **Assistant Principals: Michael Falconer, Sandra Guardado, Kevin Morris, Wendy Thigpen**

**Parent/Guardian Consent**

**Parent/Guardian of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The opportunity to “shadow” health care practitioners on-the-job is being offered to participants of the Health Careers Academy. By observing professionals at work, students will be more realistically prepared to make career choices. Approval and support is important and encouragement is appreciated. Job shadowing will usually take place during the regular school schedule.

Internship Site

Job Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guidelines for Student Behavior

Absentee Policy**:** If there is a need for absence, a student must notify the following people at least ½ hour before scheduled time.

 Mrs. Heinz: 530-917-7066

 Internship Site

Professional Dress: Please communicate with your internship site regarding their specific dress codes and what they would like you to wear. Closed-toe shoes are required. Professional appearance includes minimal make up and jewelry.

Snacking: No eating, drinking, or gum chewing on the job site

Please sign this form to indicate that you have received, read, and understood the information and return to Mrs. Heinz.

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Authorization**

Dear Parent:

In the event that your son/daughter is injured while in attendance at the internship site, every effort will be made to contact you. On occasion, difficulty has been experienced in contacting parent/guardians of students during an emergency. The law requires that written permission must be obtained from the parent/guardian before any type of medical treatment can be administered to the student. The law also requires that parent consent is obtained to release emergency contact and medical history information to an off-campus training site of your son/daughter.

Therefore, a signed medical authorization form is requested by the parent/guardian to be available at school. Your signature, unless noted otherwise, also gives your consent to release emergency contact/medical history information to off-campus site personnel during internship.

Thank you for your cooperation. If you have any questions or concerns, please email me at heinzj@luhsd.net.

Should it be necessary for my child to have medical treatment while participating in the Health Careers Academy Internship, I hereby give the school district personnel permission to use their judgement in obtaining medical service and I give permission to the physician selected by the school district personnel to render medical treatment deemed necessary and appropriate by the physician. Permission is also granted to release emergency contact/medical history to the off-campus intern site of my son/daughter.

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Cell/Work # of Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Work # of Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact person other than Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

 \_\_\_\_\_\_\_\_ I do not wish to give a medical release

 \_\_\_\_\_\_\_\_ I do not wish to have my son/daughter emergency contact/medical history information released

 to their off-campus site

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Parent/Guardian Date

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**Physician’s Report**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Do you consider this person free of infectious disease and physically and emotionally able to perform the duties of this internship class?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date of Examination



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**Student Health Clearance**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor’s Name: Jennifer Heinz

**Immunization Record:**

Polio: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Booster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DPT : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Booster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MMR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Booster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TB Skin Testing:**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Verification for Chicken Pox**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Status for Chicken Pox (date of immunization or date of illness)



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**Certificate of Tuberculin Skin Testing**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a positive Tuberculin skin test?

 Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of testing Site

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Dosage/Solution

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Reading mm Induration

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse’s Signature

**Student Emergency Contact**

**Confidential Information**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Careers Classroom: \_\_\_\_\_\_\_\_\_\_ Instructor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If an emergency, illness, or injury occurs at school or a school related function, please give names of persons to be called:

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

English-speaking: \_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_No

If No, language spoken is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of serious emergency and contacts cannot be reached, please give us thename of the physician or hospital to be called and if necessary, a preference for ambulance service:

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History/Information

Medication currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have a history of:

 Rheumatic Fever \_\_\_\_\_ Heart Trouble \_\_\_\_\_ Epilepsy \_\_\_\_\_ Kidney Disease \_\_\_\_\_

 Congenital Defects \_\_\_\_\_ Asthma \_\_\_\_\_\_ Tuberculosis \_\_\_\_\_ Diabetes \_\_\_\_\_\_

 Allergies \_\_\_\_\_ (If yes, allergic to what?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Experience Contract**

Students enrolled in this course must abide by the terms set forth in this contract. Signature below indicates that you have read and understood terms in this contract

1. Students will be allowed to start internship only if guardian consent/health clearance packet is completed and turned in to Mrs. Heinz.
2. Students will show good citizenship in class and at internship with **NO TARDIES** and **NO TRUANCIES**
3. Students will be responsible to call intern site and instructor no later than ½ hour before scheduled time
4. **No Show, No Call** is an absence if student has not called both site and instructor. Three will earn student a **withdrawal F**
5. Acceptable excuses include: Illness & family emergencies
6. Lunchtime may be used to get back to class.
7. Any student not returning to school for 3rd/7th or having excessive tardies to those classes will get a withdrawal F
8. Students only have permission to leave campus for internship. The time should not be used to go other places.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Student Signature



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**Student Confidentiality Agreement**

**To All Students Enrolled in the Internship Program:**

The school acknowledges both a legal and ethical responsibility to protect the privacy of patients and employees. Consequently, the indiscriminate or unauthorized review, use or disclosure of personal information, medical or otherwise, regarding any patient or employee is expressly prohibited.

Except when required in the regular course of business, the discussion, use transmission or narration in any form, of any patient information which is obtained in the regular course of your internship is strictly forbidden.

Those individuals who also have access to employee information are expected to respect and treat the confidentiality of such information in the same manner as that of patient information.

Any violation of this policy shall constitute grounds for severe disciplinary action, including possible termination of the offending student from the program.

I HAVE READ AND UNDERSTAND THE SIGNIFICANCE OF THIS POLICY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature

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**Internship Transportation & Liability Waiver**

As parent/guardian of a student in a Liberty Union High School District career academy, I agree to arrange transportation for the student and will accept liability. Transportation for the program is the responsibility of the parent and the student. The school will not authorize or be responsible for the mode of transportation used.

I further absolve and release the Liberty Union High School District from any and all responsibility and liability whatsoever, with regard to any mental or physical injury the student may suffer from any and all causes while participating in the internship program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date





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**Accident Procedure Sheet**

1. Emergencies:
	1. Excessive Bleeding
	2. Stoppage of Breathing
	3. Ingestion of Poinson
	4. Fractures
	5. Burns
	6. Drug Overdoses

In these cases, call a local doctor & ambulance. If a resuscitator is required, inform at the time of the ambulance call. If no doctor is available, send the ambulance directly to the hospital and call ahead.

Then:

1. Immediately inform the Internship Instructor
	1. Instructor: Jennifer Heinz
	2. Phone: 530-917-7066
2. If you cannot reach the instructor, call the principal
	1. Principal: Pat Walsh
	2. Phone: 925-634-3521 ext. 5201
3. If none of the above are available, call the school office
	1. 925-634-3521 ext. 5212
4. Inform parent/guardian
	1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Minor injuries may be handled locally, but notification as per above instructions must be followed in ALL cases.
	1. If needed, Internship Instructor will come to job site
6. If student becomes ill while at the job site:
	1. Inform Site Supervisor
	2. Inform Internship Instructor
		1. Jennifer Heinz
		2. 530-917-7066
	3. If instructor is not available, call school office: 925-634-3521 ext. 5212