



**Cascades East**  
Area Health Education Center

# PERMISSION and CONFIDENTIALITY FORM

Student to complete **all highlighted** areas. A parent/guardian signature is required even if student is over 18.

## CONFIDENTIALITY STATEMENT AGREEMENT

I have participated in a training session that has explained to me what is expected in regards to confidentiality of patients at St. Charles during my participation in job shadowing and/or health occupations programs. I am clear about what is expected from me and have had an opportunity to have questions answered about confidentiality requirements by a St. Charles caregiver. I pledge to honor the confidentiality agreement as follows:

I, \_\_\_\_\_, hereby agree to consider **ALL** information about patients as privileged and will keep such knowledge in strict  
(student name) confidence. I agree not to discuss this information with anyone.

I understand that the care of a patient is personal in nature and **ANY** casual or other **discussions of confidential patient or hospital information** with fellow students, volunteers, visitors or friends, or confidential conversations with employees **is in direct violation of hospital policy and may result in immediate dismissal.**

Student name

Student signature

date

## EMERGENCY CONTACT INFORMATION AND HEALTH INSURANCE LIABILITY ACKNOWLEDGEMENT

Emergency contact name \_\_\_\_\_ Relationship to student \_\_\_\_\_

Day phone \_\_\_\_\_

Evening phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Zip \_\_\_\_\_

As parent/guardian of the student, I acknowledge that medical insurance is my responsibility \_\_\_\_\_

Parent Signature

## Handbook for Job Shadowing and Health Occupations Program at SCHS

I have received a copy of the Cascades East AHEC Handbook for Job Shadowing and Health Occupations Programs at St. Charles Health System. I understand that it is my responsibility to read and understand the information contained in this handbook. I understand it is my responsibility to ask any questions about the material covered in this handbook. \_\_\_\_\_ student initials

## PERMISSION FOR USE OF PHOTOGRAPHY and QUOTATIONS

I grant Cascades East AHEC at St. Charles Health System permission to use finished photographs or video(s) and quotes of the said person for purposes of program development, education, and/or program promotion. I further grant the Cascades East AHEC at St. Charles Health System the right to publish and/or publicly exhibit the photograph(s), slide(s), or video(s), online social networking and quotes in any lawful and legitimate manner for the purpose set out above. \_\_\_\_\_ student initials

