



Job Shadow Schedule Form

(To be completed by shadower and hosting department, with each section complete, prior to sending for processing)

Shadower Information:

Name: _____ Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Email: _____

Supervisor Information

Please provide the following information about the associate who will host the individual:

Supervisor Name: _____ Title: _____
Department: _____ Leader Name: _____

Observation Schedule:

Start Date: _____ End Date: _____ Total Observation Hours: _____

Date	Time	Location

Shadower Signature: _____ Date: _____

Supervising Associate: _____ Date: _____

Hosting Department Leader: _____ Date: _____

Job Shadow Medical Screening

(To be completed by shadower)

Submit a copy of the following vaccination records:

- Two MMR
- Two Varicella
- Tdap (after age 10y)
- Flu (beginning in October – ending in April)

Tuberculosis (TB) Questionnaire:

	YES	NO
Have you had a positive reaction to the TB skin test?		
Have you had an allergic reaction to the TB skin test?		
Have you ever had Tuberculosis? If yes, when was your last chest x-ray? _____		
Did you receive INH or any other medication as treatment or prevention of Tuberculosis? How long did you take the medication? _____		
Have you had close exposure to communicable pulmonary disease in the past two (2) years?		
Do you have Diabetes?		
Have you received treatment for cancer?		
Have you had any serious illnesses, injuries, surgery or medical problems? Describe: _____		
Do you have night sweats?		
Do you have a chronic cough/cough up blood?		
Have you had recent unexplained weight loss?		
I understand that should I develop any symptoms suggestive of tuberculosis, such as coughing, unexplained weight loss, and/or night sweats, I will report to my Supervisor immediately.		

Print Name

Signature

Associate Health Use Only:

SYMPTOMATIC FOR TB _____ CHEST X-RAY ORDERED _____ YES _____ NO

ASYMPTOMATIC FOR TB _____ NO CHEST XRAY INDICATED

COMMENTS: _____

NURSE SIGNATURE

DATE



Job Shadow HIPAA, Social Networking and Confidentiality Form

Shadower Name: _____
(Print)

HIPAA and Social Networking Guidelines

I have been trained on the rules and regulations of HIPAA, confidentiality and appropriate social networking use. I understand that I should refer to the HIPAA Handbook provided or contact my hosting department with any questions or concerns regarding HIPAA Privacy Regulations and how they specifically affect my observation experience.

Statement of Confidentiality

During my observation experience, I may be exposed to information that is considered strictly confidential. This includes information relating to patients, their condition and their families. I understand that this information is not to be discussed with other patients, visitors, my family or my friends. I agree to honor this confidentiality agreement during and after my time spent observing at Le Bonheur Children's Hospital.

Infection Prevention

To reduce the risk of infection, I recognize the importance of utilizing safe practices during my observations. This includes washing and/or sanitizing my hands when entering and leaving a room, as well as not entering isolation rooms/areas.

If I have a fever, draining lesions on your hands/face/arms, strep throat, cold sores, pink eye, shingles, flu/flu-like symptoms, COVID-19, or exposure to a communicable disease, I will communicate with my supervisor and not participate in that shift.

Shadower Agreement

By signing below, I understand that all of the following must be completed and honored prior to and during my time as a shadower at Le Bonheur. I acknowledge that my experience may be terminated at any point for not completing and/or not passing any of these requirements:

- Complete and submit the required documents in a timely manner.
- Respect that information acquired about patients, families, and hospital personnel is considered confidential.
- Refrain from questioning children and/or families about a child's diagnosis, their plan of care, or offering medical advice.
- Refrain from the use of social media in conjunction with observation experience, including not sharing patient related information or connecting with patients and families.
- Remain with your supervisor or designated escort at all times when not in areas accessible to the public.
- Refrain from engaging in patient care or entering isolation rooms/areas.
- Follow instructions and guidelines as outlined by the appropriate parties associated with Le Bonheur Children's Hospital.

Signature: _____ Date: _____