

KENT CITY HEALTH DEPARTMENT SHADOW PROGRAM WAIVER AND RELEASE

I, _____, hereby acknowledge that, pursuant to my request, I am being permitted to shadow an employee at the Kent City Health Department. I understand that I am not an employee of the Health Department and that I am not covered under the Kent Health Department's workers' compensation plan. I will not be compensated for the time spent shadowing a Health Department employee. I will shadow beginning on _____ and ending on _____.

As a condition of being permitted to shadow a Kent City Health Department employee, I hereby knowingly and unequivocally waive, release and discharge any and all rights that I, my heirs, assigns, agents or other representatives may have or which hereafter may accrue to me, to file any claim, lawsuit and/or any other cause of action against the Health Department, its employees, officers, agencies and officials as a result of my participation in the Shadow Program.

I expressly desire to release the Kent City Health Department, its employees, officers, agencies and officials from any financial responsibility to me for any personal injury and/or property damage I may incur as a result of my shadow experience, even when it results from the negligence, both active and passive, of Health Department and/or its employees. I understand that accidents and injuries can arise out of my shadow activities; knowing the risk, nevertheless, I hereby agree to assume those risks and to release and to hold harmless the Kent City Health Department, its employees, officers, agencies and officials, who (through negligence or carelessness) might otherwise be liable to me (or my heirs, assigns, agents or other representatives) for damages.

No promise, inducement, or agreement has been made to me to induce me to release the Kent City Health Department from liability for any personal injury and/or property damage incurred by me as a result of my shadow experience, nor has any promise, inducement, or agreement been made to me in return for the express waiver of rights referred to above.

I understand that the Kent City Health Department has a responsibility to safeguard sensitive information about vendors or potential vendors and not to show prejudice or favoritism toward vendors or potential vendors. I will not share any information regarding these vendors or establishments with any person or entity that may result in an unfair advantage or bias towards any vendor or client of the department.

I understand that under no circumstances am I to discuss any protected health information as covered by HIPAA with any unauthorized person(s) inside or outside the Kent City Health Department. Health Insurance Portability Accountability Act (HIPAA): This federal law defines "protected health information" such as name, address, and phone number, date of birth, financial information, diagnosis and treatment of any individuals you may come in contact with during this job shadow experience.

The above individual, in my presence, acknowledged that they read and fully understood the meaning and consequences of the Waiver and Release of All Claims, and they signed it in my presence.

Student's Name (Please Print): _____

Student's Signature: _____ Date: _____

Parent/Guardian Name (if student is under 18 years of age): _____

Parent/Guardian Signature: _____ Date: _____

Witness' Name (Please Print): _____

Signature (Witness): _____ Date: _____