Lakeland Regional Health®

LRH Shadowing Experience

An Innovative Approach to Effective Learning

2019-2020 SCHEDULE

All sessions will take place at the Lakeland Regional Health Medical Center campus from 8:00 a.m. until 3:00 p.m.

Fall 2019 Dates	Spring 2020 Dates
Thursday, September 12, 2019 *Application Deadline:* *August 29th*	**Thursday, April 9, 2020** *Application Deadline:* *March 26th*
Thursday, October 17, 2019 *Application Deadline:* *October 3rd*	**Thursday, May 7, 2019** *Application Deadline:* *April 23rd* **(For Medical Academies)**

Provided in partnership with the Polk County School-to-Work Program

This program is open to Polk County students. Participants who are currently enrolled in the Health Occupations, Junior Auxiliary or other healthcare related activities receive priority acceptance.

Space is limited. An application must be submitted for each date selected.
Max of 1 Shadow day per semester per student

All applications must be submitted to school administration for processing. Lakeland Regional Health notifies the school directly of acceptance into the 1 day program.

For additional details, please speak with your Guidance Counselor or Program Director.

Application Checklist

☐ Review and submit completed application before the deadline date.

☐ Review program description/student letter in its entirety.

☐ Complete Shadow Application *(Three signatures are required)*

☐ Complete Shadow Preferences

☐ Complete Tuberculosis Symptom Questionnaire *(Parent signature required)*

☐ Complete Affidavit of Good Moral Character *(Notarization required)*

☐ Parental Consent Form

☐ Obtain any missing vaccinations or tests so that your school can complete their attestation.

☐ Submit completed Student Attestation *(signed by authorized school representative)*

Dear Student:

Thank you for your interest in shadowing at the Lakeland Regional Health Medical Center campus. This program is open to students no younger than 14 years of age, and who are in grades 9-12. The LRH shadowing program provides a unique opportunity for participants to spend time at an actual work site, observing professionals and support staff as they pursue their day to day activities. Following an orientation session, participants will be assigned to one of the departments in either a clinical or a business center.

Participation and enrollment is based on the application received date as this program is limited and capacity may vary. This program also requires a high level of responsibility and accountability from everyone as our first responsibility at Lakeland Regional Health is to our patients. While you are with us, please respect the privacy and comfort of our patients and families by avoiding disruptive behaviors including, but not limited to, loud talking, music or other activities that may disturb their care.

Accepted dress code for students: School uniform shirts with slacks (only); no capris, shorts or jeans permitted. Non-slip, clean, closed-toe foot footwear is suggested (no flip flops or sandals).

Students may wear their school scrub uniforms, but not colors that are already designated to our LRH professionals: black, white, blue, navy, gray, brown, teal, red, green, or apricot.

Long hair is to be secured with hair fastener. No heavy perfume/cologne or facial jewelry. Nose/tongue/eyebrow rings are not permitted. Tattoos must be covered at all times.

Absolutely NO cell phones or personal pagers will be allowed.

Failure to comply with the requirements may result in immediate dismissal from the program.

Please wear your student ID at all times during your shadow experience. ID badges are not provided.

Limit the number of personal belongings that you bring. Lakeland Regional Health cannot be responsible for personal belongings left unattended. Students may either bring their lunch or eat in the Parkview Café. Lunch is not provided by LRH.

You will be expected to provide your own transportation to and from the hospital or ambulatory clinic to which you are assigned. Designated student parking is available at the hospital next to the Laundry building located on Buena Vista Street. A sign indicates the student parking lot. Please do not park in any other lots to avoid parking violations. Students requesting to shadow at the ambulatory clinics should plan to bring a packed lunch as there are no on-site cafeteria's within the ambulatory clinics.

If you are interested in the Lakeland Regional Health Shadowing Experience, complete the attached application form and return it to the designated rep at **your school.** Selection is made on a first come, first served basis. We will make every effort to accommodate your request for a preferred interest and date. You may want to discuss your learning objectives with your teacher or guidance counselor to help you with your interest preferences.

If you have any questions or need assistance while you are at Lakeland Regional Health, please do not hesitate to contact us at 863-687-1310. If you are unable to make your shadowing experience, please call to cancel.

We look forward to your Shadowing Experience at the Lakeland Regional Health Medical Center campus!

Best Regards,
Talent Division, LRH

Lakeland Regional Health
Student Shadowing Application Form

Please PRINT CLEARLY or type

Current date (mm/dd/yyyy) _____ Shadow date(s): _____

First Name:_____Last Name:_____

Date of birth:_____ Age:_____

Preferred Name:_____

Address:_____City:_____State:_____Zip:_____

Contact phone: _____ □ Home □ Cell

Email Address: _____ School you attend: _____

School phone number: _____ Grade Level: _____

Teacher/Advisor: _____Teacher/Advisor phone number: _____

If assigned to an ambulatory clinic, would you have transportation from the hospital to the clinic after the 30-minute orientation? □ Yes □ No

Name of person to call in the event of an emergency: _____

Relationship to you:_____

Phone number to call in the event of an emergency _____

Health Insurance Company _____Policy number _____

Allergies (if any)_____ Current medical conditions (if any) _

As a participant, I agree to abide by the expectations outlined in the brochure.

(Please print this document to provide signatures below)

Applicant signature:_____

Parent/Guardian signature:_____

Teacher Sponsor signature:_____

Please give your complete application to your Instructor, Guidance Counselor or Program Director (whomever your school designates). They will review it and email it to Darcy.King@myLRH.org.

Student Experience Clinical Areas
Career Shadowing Preferences

Please share your Healthcare career interests below in 3 – 5 sentences.

Shadowing in OR/Surgery, Labor and Delivery, L&D OR, NICU, PACU, Social Work, Mental Health/Addictions Recovery, Emergency Department (Adult & Pedi), Wound Care, Morgue, or invasive procedure rooms are prohibited. FastTrack ED is permitted. Students are NOT permitted to shadow any procedure with family members as care giver or family member as the patient. Students are not permitted to shadow a close friend or close friend of a family member.

TUBERCULOSIS SYMPTOM QUESTIONNAIRE – STUDENTS

Student Name:		**Today's Date:** (mm/dd/yyyy)
School Name:	**Student's DOB**(mm/dd/yyyy)	**Student's Phone Number:**
Parent/Guardian's Name:	**Parent's Phone Number:**	
Parent's Signature (please print this document to provide signature)		

1. In the last 3 months, has the above student had any of the following symptoms?

YES	NO	
☐	☐	**Coughing up blood**
☐	☐	**Hoarseness lasting 3 weeks or more**
☐	☐	**Persistent cough lasting 3 weeks or more**
☐	☐	**Unexplained, excessive fatigue**
☐	☐	**Unexplained, persistent fever lasting 3 weeks or more**
☐	☐	**Unexplained, excessive sweating at night**
☐	☐	**Unexplained, weight loss**

AFFIDAVIT OF GOOD MORAL CHARACTER

STATE OF FLORIDA
COUNTY OF _____

BEFORE ME this day personally appeared _____
who, being duly sworn, deposes and says:

I hereby attest that I am of good moral character, that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

(a) Section 415.111 relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(b) Section 782.04 relating to murder.

(c) Section 782.07 relating to manslaughter.

(d) Section 782.071 relating to vehicular homicide.

(e) Section 782.09 relating to killing an unborn child by injury to the mother.

(f) Section 784.011 relating to assault, if the victim of the offense was a minor.

(g) Section 784.021 relating to aggravated assault.

(h) Section 784.03 relating to battery, if the victim of the offense was a minor.

(i) Section 784.045 relating to aggravated battery.

(j) Section 787.01 relating to kidnapping.

(k) Section 787.02 relating to false imprisonment.

(l) Section 794.011 relating to sexual battery.

(m) Chapter 796 relating to prostitution.

(n) Section 798.02 relating to lewd and lascivious behavior.

(o) Chapter 800 relating to lewdness and indecent exposure.

(p) Section 806.01 relating to arson.

(q) Section 810.02 relating to burglary.

(r) Chapter 812 relating to theft, robbery, and related crimes, if the offense is a felony. (See 812.014, 812.0145, 812.015, 812.016, 812.019, 812.0191, 812.0195, 812.081, 812.13, 812.131, 812.133, 812.135, 812.14, 812.155, 812.16).

(s) Section 817.563 relating to fraudulent sale of controlled substances, only if the offense was a felony.

(t) Section 826.04 relating to incest.

(u) Section 827.03 relating to abuse, aggravated abuse and neglect of a child.

(v) Section 827.04 relating to contributing to the delinquency or dependency of a child.

(w) Section 827.071 relating to sexual performance by a child.

(x) Chapter 847 relating to obscene literature.

(y) Chapter 893 relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

I further attest that I have not been judicially determined to have committed abuse or neglect against a child as defined in Section 39.01(2) and (44), Florida Statutes; nor do I have a confirmed report of abuse, neglect, or exploitation as defined in Section 415.102, Florida Statutes; nor have I committed an act which constitutes domestic violence as defined in Section 741.28, Florida Statutes.

Under the penalties of perjury, I declare that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

_____
AFFIANT

OR

To the best of my knowledge and belief, my record may contain one of the foregoing disqualifying acts or offenses:

_____
AFFIANT

SWORN TO AND SUBSCRIBED before me this _____ day of _____, 20__, by _____, who is personally known to me or has produced _____, as identification, and who did take an oath.

_____
Signature of Notary Public-State of Florida

_____
Print, Type or Stamp Name of Notary Public

_____
Title or Rank

_____
Serial Number, if any

Parental Consent, Medical Authorization, and Release of Liability Form

Name of Student: _____ Age: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent(s) Business Phone: _____ Parent(s) Cell Phone: _____

Parent(s) Home Phone: _____

Name of Student's High School: _____

Health Insurance: ☐ Yes ☐ No Policy Number: _____

Insurance Company: _____

I, _____, (name of parent) the parent and/or legal guardian of

my minor child, _____, (name of child) do hereby give permission for my child to attend and participate in a supervised work-based educational program at Lakeland Regional Medical Center, Inc. (the "Hospital") sponsored by The School Board of Polk County Florida, and/or the Hospital. I understand that my child, by participating in a supervised work-based educational program, is in no way being employed by the Hospital, and my child shall not be entitled to receive any compensation, wages, insurance, or work benefits from the Hospital as a result of said participation.

Reasonable Suspicion Drug Testing. I hereby give consent and authorize the Hospital to perform reasonable-suspicion drug testing of my child when my child's performance, behavior, conduct, appearance or other observable characteristics suggest drug use or possession of drugs while participating in a work-based educational program at the Hospital.

Medical Authorization. In the event my child is injured or becomes ill while at the Hospital, I hereby authorize the Hospital and its personnel to provide appropriate medical care or treatment to my child as they deem necessary or advisable. I understand and agree that I shall be liable for all costs and expenses incurred in connection with such medical care or treatment rendered to my above-mentioned minor child pursuant to this authorization.

Release of Liability. In consideration of my minor child listed above being accepted for participation in a work-based educational program at the Hospital, I do for myself and for and on behalf of said child, hereby release, forever discharge and agree to hold harmless the Hospital, and its related and affiliated corporations, officers, directors, employees, administrators, and agents, from any and all claims, causes of action, damages, and demands whatsoever in law or in equity, including without limitation any and all claims or causes of action for personal injury, sickness, or death, as well as property damages and expenses of any nature whatsoever, which may be incurred by me or my child resulting from my child's participation in a work-based educational program at the Hospital or resulting from any reasonable-suspicion drug testing of my child.

I acknowledge that I have read this consent and release in its entirety and understand fully its contents and voluntarily execute it realizing what I am doing by signing it. I further acknowledge that all of my questions have been answered to my satisfaction and that I have proper legal custody of my child named above.

_____ Date: _____

(Parent or Legal Guardian Signature)

_____

(Print Name of Parent or Legal Guardian)

State of Florida
County of _____

The foregoing Parental Consent, Medical Authorization, and Release of Liability Form was acknowledged before me this _____ day of _____, 20____, by _____ (name of parent or guardian) who is known to me or who has produced _____(type of identification) and who did take an oath.

[SEAL]

_____
Signature of Notary Public

_____
Print, Type or Stamp Name of Notary Public

STUDENT ATTESTATION

Dear Sir or Madam:

I hereby certify that the student whose name appears below has complied with all of the requirements set forth in the Affiliation Agreement between Lakeland Regional Medical Center, Inc. ("LRH"), and The School Board of Polk County, Florida (the "School Board"), including, without limitation, the following:

(i) Attestation of the individual's good moral character; as affirmed by notarized Affidavit of Good Moral Character.

(ii) Compliance with the current immunization requirements. See list attached to application.

(iii) Proof that each student has current accident insurance or personal health insurance coverage for them for any personal accident or injury that may occur while at LRH; and

(iv) Proof that the student, prior to his/her initial assignment to LRH, has received a favorable teacher recommendation for participation in the particular program selected.

I further certify that the School Board has adequate records showing all of the above and would be able to provide those records to LRH if requested. This certification applies to the following student: _____.

THE SCHOOL BOARD OF POLK COUNTY, FLORIDA
(Must be signed by Rep designated by PCSB)

Sign:_____
Print Name:_____
Title:_____

Lakeland Regional Health
Immunization, Testing, of Educational Requirements for Shadow Students

The individual is required to have the following prior to being assigned to the Hospital:

1. Tetanus-Diphtheria-Pertussis (Tdap) or Tetanus and Diphtheria Toxoids (Td) booster within past 10 years, according to the following specification: Individuals who have not received the Tdap booster, or for whom vaccine status is unknown, should receive a dose of Tdap followed by Td booster doses every ten (10) years thereafter, regardless of the interval since the last dose of Td. Individuals who have not received the Tdap booster or for whom vaccine status is unknown are restricted from certain high-risk areas (including, but not limited to, OB, Pediatrics, NICU, or the Pediatric Emergency Department) or from contact with infants under the age of six (6) months;

2. M.M.R. (measles, mumps, rubella) Vaccine: any individual born after December 31, 1956, and who has no proof of immune status to measles (rubeola, also known as "hard measles") will be considered non-immune; any individual regardless of birthdate without proof of immune status to rubella (also known as "German measles") will be considered non-immune;

   Proof of immunity will consist of written documentation of one of the following:

   Documentation of receipt of two doses of M.M.R. vaccine on or after the first birthday, OR,
   Laboratory evidence of rubeola and rubella immunity;

3. Varicella (chicken pox) history and a Varicella titer. If an individual with a negative hx or titer is exposed to Varicella, the individual may not participate in clinical learning experiences at the Hospital from day 10-21 post exposure. If at any time the individual develops a Varicella rash, the individual may not participate in clinical learning experiences at the Hospital until all lesions are dry and crusted. Exposed individuals shall report their Varicella exposure to the appropriate supervisor of the Hospital;

4. Seasonal Influenza Immunization as recommended by the Centers for Disease Control and Prevention (CDC) and/or the Advisory Committee on Immunization Practices (ACIP) within the past year;

5. Completion of attached TUBERCULOSIS SYMPTOM QUESTIONNAIRE;

6. Proof of either hepatitis B vaccination, antibody testing revealing immunity to hepatitis B, or declination of hepatitis B vaccination signed by the individual who chooses not to accept vaccination (any such declination shall be in the form provided for in Title 29 Code of Federal Regulations, Part 1910.1030, as may be amended);

7. Completion of OSHA mandated blood borne pathogens education program, including instructions regarding reporting, treatment, and follow-up of blood/body fluid exposure. This requirement is met by successful completion of the Orientation Handbook when you arrive at your Shadow Day.

The Hospital is not responsible for any expense incurred by the School Board, the students, vocational trainers or faculty members as a result of obtaining or maintaining any of the above listed requirements. Notwithstanding the foregoing requirements set forth in this list, the Hospital shall have the right to revise the above listed requirements or request additional documentation for evidence of good health from time to time, including all health requirements (testing and immunization) and proof of completion of certain healthcare worker education programs.