

Parental Authorization - Clinical

I give permission for my son/daughter, _____ to participate in a

Full Name (please print)

clinical experience at Bon Secours _____. I release Bon Secours

Facility Name

_____ from all claims that may arise out of this experience. I

Facility Name

understand this is a clinical experience and my son/daughter will be in direct contact with

patients with an instructor/preceptor present. My signature authorizes Bon Secours

_____ to act in an emergency, pending care, in case of illness/injury.

Facility Name

During the clinical experience I give consent for:

1. Treatment deemed necessary by the following physicians:

a. Doctor _____ Phone Number _____

b. Dentist _____ Phone Number _____

2. Treatment of the minor at a Bon Secours location, if the above physicians cannot be reached.

Parent/Guardian Name (print) _____ **Date:** _____

I, _____ (**student name**), agree to behave in a responsible and professional manner during my clinical experience at Bon Secours _____ (**facility name**).
I understand that I must always remain with my instructor/preceptor.

Student Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____