BON SECOURS MERCY HEALTH

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**: _____