



Nursing Program
Shadow Permission Form for High School Students

Please have this form completed by the appropriate persons and return it to the School, as soon as possible, (within 2 weeks).

Return the form to:

Attention: Admissions
Reading Hospital School of Health Sciences
P.O. Box 16052
Reading, Pa. 19612-6052

Or Fax to: 484-628-0134

Parent/Guardian

I give _____ parental/guardian permission to participate in the “Student Program (Non Clinical Program)” at Reading Hospital School of Health Sciences on _____ . I understand that this experience will require absence from all high school classes during the scheduled Shadow visit.

Print Name _____ Signature _____ Date _____

Relationship to student _____

High School Representative

I release _____ from high school classes on _____ to participate in the “Shadow Program (Non Clinical Program)” at Reading Hospital School of Health Sciences.

Print Name _____ Signature _____ Date _____