READING HOSPITAL SCHOOL OF HEALTH SCIENCES
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