

I am the guardian of _____. I understand my minor child (under the age of 18) named herein wishes to observe activities at one of the clinics of Open Door Community Health Centers, including accompanying a clinician during normal clinic activities and patient interactions. I understand that my child's participation in this activity is strictly voluntary and will be done without pay, compensation or other material benefits. I understand and agree that my minor child must comply with the rules and regulations established by Open Door Community Health Centers, further, must abide by instructions given by the clinician or other clinic staff, including leaving an examination room or otherwise not interacting with patients when requested by the patient, the clinician or other clinic staff. I also understand that my child is bound by federal and state laws concerning patient rights and privacy and that all information learned about an individual patient is strictly confidential and not to be disclosed to any other person except as allowed by law.

I am aware of the basic duties and activities to be performed by my minor child and the location and environment in which my child will be volunteering. I agree that the activities and location are reasonable for his or her participation.

I understand that this volunteer activity will not conflict with normal attendance at school or other educational programs unless approved, in advance and in writing, by the school.

Printed Name of Parent/Guardian

Date

Signature of Parent/Guardian

I am the minor child identified above. I understand that I need my parent's permission, as indicated the signature above, to participate as a volunteer at a clinic of Open Door Community Health Centers. I understand that I will not be paid or otherwise receive compensation for my activities. I agree to comply with the policies of Open Door Community Health Centers. I also agree to follow the instructions of the clinician and other clinic staff with whom I will be accompanying. I also agree to honor the wishes of patients who may request that I leave the examination room or otherwise not participate in the clinician's interactions with the patient. I also understand that I am bound by federal and state laws protecting the privacy of patients and protected health information and agree to maintain such information in strict confidence and not disclose protected information to any other person except as allowed by law.

I agree to contact the clinic or clinician to arrange suitable times for my activities and to inform the clinic or clinician should I not be able to attend a pre-arranged time. If I am sick at the time of a scheduled clinic session, I agree to inform the clinic that I will not be able to participate as scheduled.

Printed Name of Volunteer/Minor Child

Date

Signature of Volunteer/Minor Child
