

Reading Hospital School of Health Sciences
Discover Nursing Summer Program Application

Please Check off:

☐ High school junior

☐ High school senior

Please Print

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Cell: _____

Email: _____

Please answer the following question:

Why do you wish to participate?

Reading Hospital School of Health Sciences

Discover Nursing Summer Program Parental/Guardian Permission Form

As parent/legal guardian I give _____ permission to participate in the Discover Nursing Summer Program offered by Reading Health System and Reading Hospital School of Health Sciences.

By signing below I state that I:

- Release Reading Health System or Reading Hospital School of Health Sciences from liability for any injury that may occur related to the participation in the above program.
- Understand that while all precautions will be taken to prevent exposure, due to the nature of the patient care activities of this program, blood and body fluid exposure may occur during this program.
- Give Reading Health System permission to do whatever lab testing is necessary in the event of an exposure to blood and/or body fluid exposure.

Signature of Legal Parent/Guardian _____

Printed Name _____

Relationship to Participant _____

Emergency Contact Information during the program:

Person _____ Relationship to participant _____

Home Telephone _____ Work Telephone _____