



### Job Shadowing Program Applicable Health Information

Please list all known allergies/significant medical conditions: \_\_\_\_\_

**Please read the following statements and sign next to the statement if you agree that the statement is accurate.**

The following immunizations are up-to-date for me / my child:

- PPD or QuantiFERON within the last 30 days
- Influenza Immunization (Required between October 1 and April 30)

I / my child will only participate in the Job Previewing Program if free from infectious disease on the day of the program.

\_\_\_\_\_  
Participant's Printed Name

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

**If under 18 years of age, notarized signature of parent or legal guardian is required.**

\_\_\_\_\_  
Parent/Legal Guardian's Printed Name

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_, ss.:

On this day, personally appeared before me

\_\_\_\_\_, to me known to be the person(s) described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her voluntary act and deed, for the uses and purposes therein mentioned.

Witness my hand and official seal hereto affixed

this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public in and for the State of \_\_\_\_\_.

My commission expires \_\_\_\_\_.