

**Parent/Guardian Consent for Observation**

I give permission for my son or daughter \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (a minor) to participate in an observational experience at Lakeland HealthCare. I release Lakeland HealthCare from all claims that may arise from this observational experience. I understand this is an observational experience only and there will be no patient care given by my son or daughter.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent/Guardian Name (Printed)

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(Home) (Work) (Cell) (Other)

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**Parent/Guardian Name (Signature)**