Volunteer/Job Shadow Release Form & Confidentiality Agreement

Name: _____

DOB: _____

Address: _____

School and Grade: _____

Phone Number: _____

Email address: _____

Preferred Date: _____

Alternate Date: _____

Dress Code, Behavior, and Confidentiality Agreement

It is our desire that your time at our facility is educational and enjoyable. As a participant in the volunteer/job shadowing program you will be representing Vista Vision through interactions with patients, employees, and guests, as such you are expected to present yourself in a professional manner. You should arrive on time and appropriately attired (business causal---no jeans, no shorts, no bare-mid drift shirts, no excessive jewelry, no shirts/pants with holes, no shirts with profanity or large logos). For your safety and protection, closed toed shoes are required.

Profanity or inappropriate conversations will not be tolerated as this behavior is inconsistent with Vista Vision's code of conduct. We will provide an area for you to place your personal belongings during your scheduled time. We ask that you turn your cell phone or electronic devices off and put them away.

As a participant in the volunteer/job shadowing program, you may be exposed to confidential information concerning Vista Vision and its patients. You promise that you will not discuss or otherwise share information regarding patient events or occurrences seen. Verbal permission from all patients must be granted before you will be allowed to observe any patient or their health information. If this permission is not obtained, you may be asked to wait in an appropriate place until the volunteer/shadow experience can resume. You promise to call and reschedule your volunteer/shadow experience if you are coughing, have a fever sore throat, or any other evidence of sickness.

Signature: _____

(Parent/Guardian Signature, if under age of 18)

Medical Information and Release

Emergency Contact: _____

Relationship: _____ Phone: _____

Medications(s)/Allergies/Conditions: _____

Medical Insurance Company Name and Policy #: _____

I, the undersigned (or parent/guardian), understand the nature of Vista Vision's volunteer/job shadowing program and the activities involved. I agree that the individual named on this form is in adequate health to perform, participate, or observe the activities carried out at this facility. I do ensure and guarantee to hold harmless Vista Vision, its staff, agents, and representatives from any responsibility for liability whatsoever resulting from the individual's actions, activities, or injury.

Signature: _____

(Parent/Guardian Signature, if under age of 18)

COVID-19 Waiver

Thank you for your interest in shadowing at Vista Vision. As with the transmission of any communicable disease like a cold or flu, you may be exposed to COVID-19, also known as the "Coronavirus," at any time or in any place. Be assured, that we have always followed state and federal regulations as recommended as well as universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and the use of our personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, optometrist, optometrist staff, and sometimes other patients at all times.

As such, you agree to wear a proper cloth, surgical, KN95, or N95 mask for the duration of your shadowing visit. You will be asked to reschedule your shadowing experience if you have had any of the following within the past 14 days: positive COVID diagnosis or exposure, shortness of breath, cough, loss of taste or smell, diarrhea, muscle aches, runny nose, sore throat, headache, fatigues, congesting, nausea, or vomiting

Although exposure is unlikely, you agree to hold harmless Vista Vision its staff, agents, and representatives for any possible exposure to COVID-19 or subsequent positive diagnosis as a result of your shadowing experience.

Signature: _____

(Parent/Guardian Signature, if under age of 18)

Please return this form at least three weeks prior to the proposed shadowing date. Please return by one of the following options below:

Mail: Vista Vision, 1513 Gregg Street, Columbia, SC 29201

Fax: 803-254-4952

Email: kcartledge@vista-eye.com

For any questions, please contact us by phone at 803-254-4951 or email at kcartledge@vista-eye.com.