Confidential Reference Form for High School Shadow Volunteers
Lehigh Valley Hospital and Health Network

Please read, sign, and take this form to the school representative of your choice
to complete the reference requirement of our program.

Consent to release student information: (to be completed by the student)

_______________________________ has asked to Shadow at Lehigh Valley Hospital. The student and his/her parents/guardian agree that a representative of the student's school may answer the hospital's evaluation form with the understanding that Lehigh Valley Hospital will hold this information in confidence.

____________________ ____
Date Student

____________________ ____
Date Parent/Guardian

Lehigh Valley Hospital confirms that the school evaluation and recommendation form referred to above is required by the Division of Education to satisfy hospital regulations.

Confidential recommendation for Shadow student: (to be completed by the reference)

____ _________________
Student's name Grade in school

	Excellent	Good	Average	Below Average
Attendance	_______	_______	_______	_______
Scholastic Record	_______	_______	_______	_______
Dependability	_______	_______	_______	_______
Courtesy	_______	_______	_______	_______
Willingness	_______	_______	_______	_______
Initiative	_______	_______	_______	_______

Comments:

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Signature: ____________________________________ Title: __________________________
School: _______________________________________ Date: __________________________

This form should be returned to Lehigh Valley Hospital, Division of Education, Attn: Kirsten Ryan, 1247 S. Cedar Crest, 2nd fl., Allentown, PA 18103 or faxed to 610-402-2203. The student will not be able to begin his/her Shadowing until recommendations have been returned.

Thank you!