Shadow Visit Permission Form for High School Students

Please have this form completed by the appropriate persons and return it as soon as possible before your scheduled SHADOW VISIT.

Return the form to:

Trinity College of Nursing & Health Sciences

Attention: Admissions

2122 25th Avenue

Rock Island, IL 61201

FAX to: 309.779.7748

Email to: Lori.Perez@trinitycollegeqc.edu

Parent/Guardian:

I give _____ parental/guardian permission to participate in the Trinity College of Nursing & Health Sciences SHADOW VISIT (non clinical) on _____ .

I understand this is an approximately four hour experience, which may require absence from high school classes in accordance with their college visit policies.

_____

Print Name Signature Date

Relationship to student: _____

High School Representative:

I release _____ from high school classes on _____

To participate in the SHADOW VISIT (non clinical) at Trinity College of Nursing & Health Sciences.

_____

Print Name Signature Date