

Print this form. Complete. Turn in to faculty first day of class.

## Associate Degree Nursing Program

### CONSENT FOR PARTICIPATION IN STUDENT LEARNING EXPERIENCES

(student name)

I am willing to participate in learning experiences for \_\_\_\_\_, Sinclair Nursing Student. I understand that these learning experiences will be limited to observation and assessment of the family and its individual members and our physical environment, along with health promotion/disease prevention interventions. No direct nursing services or medically prescribed treatments or medications will be administered by the student. All information about individuals in my family will be kept confidential; no identifying information will be recorded in the student's written documentation or shared verbally with anyone.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_