Take Our Kids to Work™ (TOKW) has three main objectives:

- To offer students a view of the work world, and to give them an understanding of its demands and opportunities.
- To allow students to see their parents or legal guardians in different roles and responsibilities and to understand what they do to support a family.
- To emphasize that education goes beyond the classroom and that the preparation of younger generations for the future is a community responsibility.

Who is eligible?

- All Grade 9 students who have a parent or legal guardian that is an employee of Providence Health Care (PHC). As of March 2007, job shadowing a physician is not allowed at all as per the College of Physicians and Surgeons of BC. (https://www.cpsbc.ca/cps/physician_resources/publications/resource?manual/clinic%20names)
- As to where students can go to and do, this is up to the Department/Unit/Program Operations Leader.

Planning TOKW Day

- Discuss the day with your leader/supervisor, particularly regarding the impact the visit may have on your workload, patients, and colleagues.
- As the parent/legal guardian, you must complete the Take Our Kids to Work™ Memorandum of Understanding – Waiver and Release of Responsibility. By signing this form, you accept total responsibility for the supervision and safety of your child/charge.
- This program is not a BC Ministry of Education or School District sponsored event. There is no third party liability coverage or WCB coverage by either the Ministry of Education or School District for this experience, nor is PHC responsible for any loss, injury, or damage, including property loss or damage which your child/charge may suffer as a result of his/her participation in the program.
- Get written permission from the Department/Unit/Program Leader to bring your child/charge to work by submitting the Take Our Kids to Work™ Memorandum of Understanding – for authorization. Certain areas of work are not appropriate locations for this event. The leader has the authority to refuse this permission if she/he feels it is inappropriate. (See the ‘Guidelines for Job Shadowing & Student Observers document CPF1200-Students Policy.)
- Ensure that the child’s basic immunizations are up-to-date and that you carry a copy of this immunization on the day of the visit.
- Discuss confidentiality and privacy issues with your child. Sign the Confidentiality Agreement.
- And attach to the Waiver and Release of Responsibility form.
- Discuss what your child should wear. Dress must be appropriate – no ball caps, shorts, inappropriate t-shirts, etc.
- Discuss what your child would like to see and learn about.
- Organize some minor assignments.

Note: For the purposes of this document, the term "patient" is used to refer to patients, residents, and clients.
Some Ground Rules

• Students may not bring friends or neighbours with them – you may only bring one student to work and you must be that student’s parent or legal guardian.

• Students must remain under parent/legal guardian supervision all day. Students are not allowed to wander through the facility unaccompanied. Any student found unaccompanied in an authorized staff-only area may be asked to leave the facility immediately.

• Students must wear identification at all times that state their name and that they are a “Grade 9 Student” and must carry their student ID cards with them.

• PHC will not supply scrub suits or laboratory jackets except in exceptional circumstances, e.g. where the student is accessing the Operating Room or needing to protect clothing.

• This experience is strictly an “observation only” experience. Students are not to engage in any work-related activities.

• Students cannot participate in direct patient care of any kind.

• Students may observe patients in a direct care or service area only with the full knowledge, consent and cooperation of the individual and according to the ‘Guidelines for Job Shadowing & Student Observers’. Parents/Guardians should consider appropriateness.

On the Day

• Provide your child with a general orientation to your department, including a review of confidentiality policies and safety procedures, and a tour of the facility.

• Introduce your co-workers.

• Explain the organization’s structure and where you fit in. Describe your job and what qualifications you needed.

• Assign the tasks that you prepared.

• Encourage your child to ask lots of questions.

• Provide time at the end of the day for your child to describe the experience.

• If there are sufficient numbers, and the site is prepared, it may be possible for students to gain other organized experiences or tours.

Questions You May be Asked

• What do you enjoy about your job?

• What does your job involve?

• What kind of experience/education is required for your job?

• Why did you choose this kind of work?

• What new skills are you learning?

• How much could I earn in this kind of job?

• What would you change about your job if you could?

• What other jobs could you get with your experience and education?

• What advice can you give me about preparing for my future?

After the Day

• Have your child share the experience with the family.

• Encourage your child to send a “thank you” note to the leader/staff.

Note: For the purposes of this document, the term “patient” is used to refer to patients, residents, and clients.
Confidentiality Agreement – High School Students

Personal Information:

Last Name: ___________________________  First Name: ___________________________

High School: ___________________________  Grade: ___________________________

Address: __________________________________________

In order to participate in an educational placement at Providence Health Care (PHC), I understand and agree to the following:

I understand that PHC is a public body that is governed by Freedom of Information and Protection of Privacy Act (FIPPA), and I agree to comply with the privacy and confidentiality policies of PHC.

I understand that all personal information concerning staff and patients who receive services from PHC, including, but not limited to, medical records relating to patients and residents, may not be communicated or released to anyone in any manner, except as authorized by PHC.

I understand that Confidential Information not only includes “Personal Information” as defined by the (FIPPA) but also includes any information related to the business or operations of PHC, which is not generally known or available to the public.

I agree to take all reasonable steps to protect all Confidential Information from disclosure, and will not copy, alter, destroy, retain, disclose or reproduce any Confidential Information.

I agree to limit my activities within PHC to those areas and activities which are described in the attached document, and also agree to abide by all policies, procedures, rules and regulations of PHC.

I understand and agree that PHC will not be responsible for providing Workman’s Compensation benefits while in attendance at the premises.

I understand that compliance with confidentiality is a condition of my educational experience at PHC and that failure to comply may result in immediate dismissal from PHC, in addition to legal action by PHC and others.

I consent to PHC collecting, using and disclosing of personal information about me for the purposes of my placement and ensuring the safety of patients and others, or for conducting investigations and if required by law.

DATED (mm/dd/yy) ___________________________  Student Signature: ___________________________

I am the parent/legal guardian of ___________________________, and hereby agree to the terms of the agreement above on my own behalf and on behalf of my minor child and do hereby release PHC, its directors, officers, employees, volunteers, agents and contractors, including attending physicians, from any and all loss, damage or liability related to my child’s placement.

DATED (mm/dd/yy) ___________________________

Parent/Legal Guardian  
(please print) ___________________________  Signature: ___________________________
Disclaimer Clause

Providence Health Care (PHC) is not responsible for any loss, injury, or damage, including property loss or damage, which my child/charge (print full name) may suffer as a result of his/her participation in the “Take Our Kids To Work” program (the “Program”) at PHC.

The Agreement

“Take Our Kids To Work” program is an introduction to the Career Preparation Program for high school students. The objective of this day is to offer students a view of the work world and give them an understanding of its’ demands and opportunities.

I, _________________ (print full name), as an employee of PHC or physician with PHC privileges, undertake absolute responsibility for the personal and exclusive supervision of my child/charge, while s/he accompanies me to work at __________________________ (worksite) on _____________, 20___ for the purposes of the above-noted Program.

I understand and agree that my child’s/charge’s attendance at a PHC worksite is to be strictly observational and my child/charge is not to be involved in client care or other services at PHC in any direct “hands-on” way.

I accept the responsibility to make sure that my child/charge complies with all the policies, procedures, and safety protocols of PHC.

I will make sure that my child/charge maintains in strictest confidence, all client information that my child/charge may come in contact with during the observational experience under the Program.

I undertake to obtain verbal consent from all clients that my child/charge may be in contact with throughout this experience before allowing my child’s/charge’s attendance with the particular client.

In consideration for PHC allowing my child/charge to participate in the Program at PHC (under the terms and conditions described above), I hereby agree to indemnify and hold harmless PHC, and any of its officers, employees, servants, agents and contractors from any and all liability for any loss, injury or damage, including property loss or damage, which my child/charge may suffer as a result of participation in the Program.

I confirm that my child’s/charge’s basic childhood immunizations are up to date.

I acknowledge that I am over nineteen (19) years of age and I have read this liability release and I accept the above disclaimer clause as evidenced by my signature.

Dated this _________________ day of, 20__.

______________________________
Signature of Parent/Legal Guardian

______________________________
Parent/Legal Guardian Name (please print)

Dated this _________________ day of, 20__.

______________________________
Signature of Department/Unit/Program Leader

______________________________
Leader Name (please print)

______________________________
Department/Unit/Program

Copy to Parent /Legal Guardian 9/6/05 Original to Supervisor/Leader