WKCTC DIAGNOSTIC MEDICAL SONOGRAPHY PROGRAM

VOLUNTEER INFORMED CONSENT

VOLUNTEER'S NAME _____ DATE _____

SIGNATURE _____

PARENT/GUARDIAN SIGNATURE (if minor child) _____

WITNESS _____ _____

INFORMATION

Purpose: The Diagnostic Medical Sonography program provides instruction to students on techniques used in Sonography. Volunteer patients are needed for student practice. The medical sonograms are supervised in a laboratory setting and in no way should be considered medical evaluation.

Procedures: Students will be practicing Sonography with you or your child. They will practice informed consent to inform you of the medical Sonography they will perform on you or your child.

Liability release:
I, the undersigned, desire to be a volunteer patient for the Diagnostic Medical Sonography program.

I understand the techniques practiced in the laboratory setting are supervised. I for myself, my heirs, successors or assigns, hereby release and hold harmless WKCTC and its Board of Directors and the Kentucky Community and Technical College System (KCTCS) and its Board of Regents and any WKCTC/KCTCS agents, offices, employees, and volunteer organizers of off-campus college visits from any and all claims, demands, causes of actions or damages which may accrue on account of bodily or personal injury, property damage or death arising out of my participation including damages, injury or death arising from the negligence of the aforesaid parties. I, for myself, heirs, successor, and assigns, hereby assume any and all risks attendant to my participation.