Student Paperwork

INCLUDES:

- HEALTH FORM – Complete and return (Pages 2-3)
- TB MASK SCREENING – Complete and return (Page 4)
- CONFIDENTIALTY FORM – Complete, Sign, and return (Page 5)
- WAIVER AND RELEASE OF MEDICAL LIABILITY – Complete, Sign, and return (Page 6)

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Health Form and Immunization Documentation Directions

Thank you for your interest in completing your rotation at Children's. One of the most important pieces of information we collect from you is your health information.

- Children's does not provide any immunizations for students. Students must get them at their own expense.
- Students are required to complete the Health Form. It will not be accepted if it is not complete and legible.
- Documentation is required for everything on the Health form. All documentation must be easily readable.
  Health Form and Documentation must be submitted together. Ensure you return everything correctly the first time so you don't get delayed due to Occ Health clearance.
- If you must resubmit anything, you must resubmit entire file.
- Students only must complete 1 of the given options to complete requirements below.

TB testing: Test is required annually and must be current through your entire rotation.

Option 1 - Quantiferon Gold TB, IGRA or T-SPOT blood test

Option 2 - Two rounds of TB skin testing within one year

- TST testing – Student must show evidence of 2 skin tests within the same year. An acceptable form of documentation should include both the date applied, date read and signed by a Medical professional. If this is the first time the student will have a TB test, for the 2017 year, the TST testing must be a two-step Mantoux tuberculin skin test. Please refer to the CDC guidelines below for further instruction: https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm
- A chest x-ray is required, if you have had a positive TB test. A two-view chest x-ray must be provided as well as x-ray documentation stating, free from disease and includes signature of the Radiologist.

Varicella, aka Chickenpox is a common childhood illness that is now prevented by the Varicella vaccine.

Option 1 - If you were born before 1980 and positively remember having chickenpox, this will serve as documentation of immunity. *If you have not had chicken pox you must go to option 2.*

Option 2 - If you were born before 1980 and have not had the disease, or if you were born in or after 1980, you will be required to either provide the dates of two doses of the Varicella vaccine or a blood titer (test) proving immunity

Option 3 - Provide positive titer for varicella

Measles, Mumps and Rubella are also illnesses that are prevented by vaccinations.

Option 1 - You will need to provide the dates of your vaccinations for Measles, Mumps and Rubella and documentation of a MMR booster

Option 2 - Provide the dates of two MMR immunizations

Option 3 - Provide positive titer for MMR

Tetanus/Diphtheria vaccine is required every 10 years.

There are two types of vaccines that are acceptable at Children's, the Td (Tetanus and Diphtheria) vaccine and the Tdap (Tetanus, Diphtheria and Pertussis) vaccine.

- Tdap vaccine is required if you are in direct patient care. If you are due for a Tetanus vaccine it is recommended that you receive the Tdap vaccine.
- You will need to provide the documentation of your current last Tetanus/Diphtheria vaccination or Tdap.

Influenza Immunization may come in two forms, an injection or a nasal spray (if available); both are acceptable at Children's.

Documentation of this immunization is required during flu season.

- Typically flu season is from September through May but can vary year-to-year.
- If you are completing this process after flu season has ended you are not required to provide anything.
- If you are here during flu season, after you are cleared for your rotation, you are required to provide proof of an influenza immunization.

HEP B vaccine

- Only required if you are at risk for exposure to blood/body fluids
- You will need to provide the dates of your 3 vaccinations/booster or a positive titer.

Documents that are accepted by Children's, the following are accepted:

- Vaccine records from a physician's office; must be signed by the physician or the person who administered the vaccine; must include date of administration; example is Childhood Immunization Record
- Vaccine administered at a clinic; includes date of administration, lot number, signature of person who administered vaccine

Records that Children's will not accept as proof of documentation:

- A school's Nursing Immunization Form even if it has been signed off by a physician
- The University's Health Record
- A cash register receipt for a vaccination

NAME: _____ EMAIL: _____ PHONE #: _____
SCHOOL: _____ HOSTING DEPARTMENT: _____
ROTATION END DATE: _____

HEALTH FORM- REQUIRED FOR FACULTY, STUDENTS & CONTRACT STAFF

Full documentation is required for all the following requested records

1. TB TESTING *(One of 2 options below must be met – see directions for more details)*

Option 1	QFT, IGRA or T-spot (MM/YY):	Results:
Option 2 Student must show evidence of 2 skin tests within the same year.	*TB Skin Test 1 Date (MM/DD/YY):*	*Results:*
	TB Skin Test 2 Date (MM/DD/YY):	Results:

If you must update any immunizations, you should complete your TB testing prior to receiving your vaccinations.

2. VARICELLA, aka Chickenpox *(One of the 3 options below must be met)*

Option 1	If you were born BEFORE 1980 have you had the Chickenpox? *If no history of chickenpox you CANNOT use this option*	DOB:
Option 2	If you were born AFTER January 1, 1980, please list the dates of both Varicella immunizations	Varicella 1 Date (MM/YY):
		Varicella 2 Date (MM/YY):
Option 3	Or provide a blood titer (test) confirming Varicella immunity	Titer Date: Results:

It is required that you have a blood titer done to prove immunity if you had the Chicken Pox after 1980. Proof of Chicken Pox will not suffice.

3. MEASLES, MUMPS AND RUBELLA *(One of the 3 options below must be met)*

Option 1	Please list the following:	Measles Immunization	Date (MM/YY):
		Mumps Immunization	Date (MM/YY):
		Rubella Immunization	Date (MM/YY):
		MMR Immunization Booster	Date (MM/YY):
Option 2	Or provide the dates of two Measles, Mumps and Rubella (MMR) immunizations:	MMR Immunization 1	Date (MM/YY):
		MMR Immunization 2	Date (MM/YY):
Option 3	Or provide blood titer (test) confirming Measles, Mumps and Rubella immunity	Measles Titer Date: _____ Mumps Titer Date: _____ Rubella Titer Date: _____	Results:_____ Results: _____ Results: _____

4. TETANUS DIPHTHERIA AND/OR TETANUS, DIPHTHERIA, PERTUSSIS IMMUNIZATION (Current within last 10 years)

Td Date (MM/YY):	Tdap Date (MM/YY):

5.* INFLUENZA IMMUNIZATION *(Shot or Mist)

****Documentation is required ONLY if you are completing rotation during flu season (typically Sept- May)***

Influenza Injection Date (MM/YY):	Influenza Mist Date (MM/YY):

6. CLINICAL ROTATION ONLY - THREE DOSES OF HEPATITS B VACCINE

Required only – if at risk for exposure to blood/body fluids ☐ Check the box if this N/A because you are not at risk for exposure.	*Option 1*	Vaccine1	Date (MM/DD/YY):
		Vaccine 2	Date (MM/DD/YY):
		Vaccine 3	Date (MM/DD/YY):
	Option 2	Positive Titer	Date (MM/YY): Results:

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ANNUAL TUBERCULOSIS/N95 MASK SCREENING

Name	Date of Birth
Preferred Email Address	Preferred Phone Number

☐ Employee	☐ Medical Staff	☐ Med Educ.	☐ Volunteer	☐ Other
CMC Employees including APN's ID# _____	Attending MD, Dental, Allied Health, Other ID# _____	Fellow, Resident, Rotating Resident, other ID# _____	Annual, 1st year, pastoral care, other ID# _____	Traveler, Other Title: _____ ID# _____

In the past year, have you:		
Had a known exposure to TB and were ***not*** wearing a mask	☐ YES	☐ NO
Diagnosis of Pneumocystis Carinii Pneumonia	☐ YES	☐ NO
Diagnosis of being immune compromised	☐ YES	☐ NO
Taking medications that are immunosuppressive	☐ YES	☐ NO
Cough lasting longer than three weeks	☐ YES	☐ NO
Loss of appetite	☐ YES	☐ NO
Unexplained weight loss	☐ YES	☐ NO
Profuse night sweats	☐ YES	☐ NO
Fatigue (unusual tiredness)	☐ YES	☐ NO
Coughing up blood	☐ YES	☐ NO
Chills and/or fever	☐ YES	☐ NO
Chest pain	☐ YES	☐ NO
Difficulty breathing	☐ YES	☐ NO
Traveled outside the United States	☐ YES	☐ NO
Volunteered in a homeless shelter or jail?	☐ YES	☐ NO
Had visitors from a foreign country stay with you	☐ YES	☐ NO
If you answered yes to any of the above, please explain.		
Have you ever had a TB Test?	☐ YES	☐ NO
Have you ever had a positive TB Test?	☐ YES	☐ NO

If yes, please list date performed
☐ Skin Test _____ ☐ Quantiferon Blood Test _____

Was a Chest X-ray completed and reviewed by a radiologist?
☐ Date: _____

TB Respirator N95 Mask (if yes, consider retesting)		
Any changes in facial structure such as jaw surgery, facial hair, new eyeglasses, etc.	☐ YES	☐ NO
Weight gain or loss of 15 pounds or more?	☐ YES	☐ NO

_____ _____
Your Signature Date

_____ _____
Occupational Health Nurse Date

THIRD-PARTY CONFIDENTIALITY AGREEMENT

I understand that while I am on the property of any Children's Health System of Texas ("Children's Health") facility, I may have access to Confidential Information, including patient protected health information and information that is non-public, proprietary or otherwise confidential in nature (collectively "Confidential Information"). I may learn of or have access to this Confidential Information orally, by observation, or through a computer system, documents or other means. I understand and agree that Confidential Information will be kept confidential and will not be disclosed by me without prior written consent from Children's Health or from a Patient. I agree to use appropriate safeguards to prevent the use or disclosure of Confidential Information.

Proprietary and Other Confidential Information:
Confidential Information may include proprietary and other confidential information, including, without limitation, information about business practices, business strategies, development and research activities, finances, trade secrets, physicians, providers, employees, quality review, employee health information, patient lists, information received from and/or belonging to patients, providers, customers or other persons who do business with Children's Health, or any other information related to Children's Health operations that is not generally available to the public. Access to Confidential Information is permitted only as authorized and as required for legitimate purposes in the performance of my role and/or access to Children's Health premises. I UNDERSTAND AND ACKNOWLEDGE THAT SHOULD I OBTAIN ACCESS, EITHER INTENTIONALLY OR UNINTENTIONALLY, TO ANY CONFIDENTIAL INFORMATION WHILE ON-SITE AT CHILDREN'S HEALTH, I AM REQUIRED TO KEEP SUCH INFORMATION CONFIDENTIAL.

Patient Health Information:
I understand that to comply with state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act"), I will not have access to patient Protected Health Information (PHI) without proper authorization. I further understand that I may not obtain, or make copies of, PHI to take outside of Children's Health without a Children's Health-approved authorization form signed by the patient or legally authorized representative of the patient and processed by the Health Information Management department (HIM).

I UNDERSTAND AND AGREE THAT SHOULD I OBTAIN ACCESS TO ANY PHI WHILE AT CHILDREN'S HEALTH, I AM REQUIRED BY LAW TO KEEP ALL PHI CONFIDENTIAL AND NOT DISCLOSE SUCH INFORMATION. I UNDERSTAND AND AGREE, HOWEVER, THAT SHOULD I DISCLOSE ANY PHI, EITHER INTENTIONALLY OR UNINTENTIONALLY, I AM REQUIRED TO NOTIFY A CHILDREN'S HEALTH PRIVACY OFFICER OF THE DISCLOSURE WITHIN TWO (2) CALENDAR DAYS OF MAKING THE DISCLOSURE. I UNDERSTAND THAT THE UNAUTHORIZED DISCLOSURE OF PHI IS A VIOLATION OF FEDERAL AND STATE LAWS AND MAY BE PUNISHABLE BY CIVIL MONEY PENALTIES OR OTHER MEANS ALLOWED BY LAW.

I am on-site for the following reason:

- ☐ Procedure Observation
- ☐ Site Visit
- ☐ Job Shadowing
- ☐ Training
- ☐ Other_____(specify purpose)

I understand and agree to abide by these confidentiality requirements. I understand that my violation of this Agreement may result in the termination of my visitation status at Children's Health.

_____ _____
Printed Name Date

_____
Signature

This section to be completed if individual is under 18:
I agree to be responsible for compliance by my son/daughter under the age of 18, with the terms above.

_____
Signature and printed name of student's parent/legal guardian, if individual is under 18

WAIVER AND RELEASE OF MEDICAL LIABILITY

I, _____, (Student's/Instructor's Name) along with my heirs, successors, and assigns, hereby agree and acknowledge that participation in the educational rotation, practicum, or internship at Children's Health System of Texas ("**Children's**") may involve a risk of injury and I hereby indemnify and hold harmless Children's, its agents and employees ("**Children's**") from any and all claims, suits, liability, judgments, and costs, arising from and/or related to any personal injuries, damage to personal property and the results therefrom, ensuing from my participation in the educational, practicum, or internship experiences at Children's.

I further agree to indemnify and hold Children's harmless for any injury or medical problem I may acquire during my participation in the educational, practicum, or internship experience. I agree to pay my own medical costs related to any injuries or illnesses that I incur during my participation in educational, practicum, or internship experiences. I further agree that Children's shall not be responsible for payment of medical services and agree that any Children's insurance that may exist does not cover my medical costs.

I have read the above waiver and release in its entirety and sign below voluntarily. I intend my signature to be a complete and unconditional release of Children's liability to the greatest extent allowed by law.

_____
Signature

_____ _____
Printed Name Signature Date

_____
Permanent Address

_____
Email

_____
Phone Number

_____
Dates at Children's

_____
Sponsoring College/University

_____
Program/Discipline Name

_____
Sponsoring Professor's Printed Name