Student Paperwork

INCLUDES:

- HEALTH FORM – Complete and return (Pages 3-4)
- TB MASK SCREENING – Complete and return (Page 5)
- CONFIDENTIALTY FORM – Complete, Sign, and return (Page 6)
- WAIVER AND RELEASE OF MEDICAL LIABILITY – Complete, Sign, and return (Page 7)

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Health Form and Immunization Requirements

Thank you for your interest in completing your rotation at Children's Health. For your safety and the safety of our patients, we require that you meet all occupational health requirements outlined in this document. Please be advised that Children's Health does not provide immunizations for students.

You are required to provide appropriate documentation for ONLY one of the outlined options for each requirement below. Complete the Health Form and submit both the Health Form and all required immunization records to OHStudents@Childrens.com.

Tuberculosis (TB) Test: *(Test is required annually and must be current through entire rotation)*
Option 1: TB blood test (one of the following)

- Quantiferon Gold TB
- T-SPOT blood test

Option 2: Evidence of 2 Mantoux tuberculin skin tests (TST) within the same year.
An acceptable form of documentation should include both the date applied, date read, measurement and signed by a medical professional.
Option 3: Students with a past positive TB test must provide positive test result (PPD with measurement or QFT), a two-view chest x-ray and documentation from a provider stating student is free from disease within the last year.

Varicella (chickenpox)
Option 1: Two documented doses of varicella vaccine
Option 2: Positive titer for varicella

Measles, Mumps and Rubella (MMR)
Option 1: Two documented doses of measles, mumps, rubella (MMR)vaccine
Option 2: Positive titer for measles, mumps, rubella (MMR) vaccine

Tetanus, Diphtheria (Td) or Tetanus, Diphtheria and Pertussis (Tdap)
Option 1: Documentation of Tdap given on/after age 11yrs and either Tdap or Td within the last 10 years

Influenza *(required during flu season only)*
Option 1: Documentation of either injectable or nasal flu vaccine
Option 2: Not applicable – Rotation does not fall within flu season which is typically September through May but may vary year to -year.

Hepatitis B *(Recommended for any health care personnel HCP in clinical setting)*
Option 1: Documentation full hepatitis B vaccine series
Option 2: Documentation of a positive hepatitis B titer
Option 3: Currently receiving hepatitis B series
Option 4: NOT assigned to a clinical area during rotation

COVID-19 *(Not currently required, but if received, please list dates)*
The COVID-19 vaccine is not a requirement for applicants at Children's Health. If you have received the COVID-19 vaccinations, please submit your records so that they are on file (proof of both doses of a two-dose series or proof of a single dose vaccine and/or booster).

NAME: _____ EMAIL: _____

PHONE #: _____SCHOOL/COMPANY:_____

HOSTING DEPARTMENT: _____ROTATION END DATE: _____

HEALTH FORM- (REQUIRED FOR FACULTY, STUDENTS & CONTRACT STAFF)

Full documentation is required for all the following requested records

1. Tuberculosis (TB) TESTING

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 receive any immunizations, you should complete your TB testing prior to receiving your vaccinations.

2. VARICELLA (aka Chickenpox)

Option 1	Two doses of Varicella	Varicella 1	Date:
		Varicella 2	Date:
Option 2	Blood titer (test) confirming Varicella immunity	Results:	Date:

3. MEASLES, MUMPS AND RUBELLA (MMR)

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

4. TETANUS, DIPHTHERIA, PERTUSSIS (Tdap) and/or TETANUS DIPHTHERIA (Td) (Must have one Tdap and must have had Td or Tdap with last 10 years)

Option 1	Tdap after on/after age 11yrs of age AND Td or Tdap within last 10yrs	Tdap Date:	Td Date:

5. INFLUENZA IMMUNIZATION *(Injection or Mist)*

Option 1	Influenza Injection Date (MM/YY):	Influenza Mist Date (MM/YY):
Option 2	Not Applicable – rotation NOT during flu season *(flu season typically September-March)*	Hosting Department:

6. COVID-19 (Not currently required, but if received, please list dates)

Option 1 *Two dose series*	Vaccine1	Date:
	Vaccine 2	Date:
Option 2 *1 dose series*	Vaccine1	Date:
Option 3 *WHO approved vaccine*	Vaccine 1	Date:
	Vaccine 1	Date:
COVID-19 Booster	Booster	Date:

7. CLINICAL ROTATION ONLY - HEPATITS B VACCINE

Option 1 *Two or three dose series*	Vaccine1	Date:
	Vaccine 2	Date:
	Vaccine 3 (if applicable)	Date:
Option 2	Positive Titer	Date: Results:
Option 3	Not Applicable – rotation NOT in a clinical area	Hosting Department:

***Please ensure all documents are legible and are acceptable forms of documentation. See additional details below.**

Acceptable forms of documentation include:

- Immunization records from a physician's office, medical clinic, health department
- Must include student's name, date of birth (DOB), date of vaccine administration, manufacturer

Examples of records NOT accepted as proof of immunization:

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

children's health

ANNUAL TUBERCULOSIS EVALUATION

Name:			Date of Birth:	
Preferred Email Address:			Preferred Phone Number:	
☐ Employee	☐ Medical Staff	☐ Med Educ.	☐ Volunteer	☐ Student
CMC Employees including APN's ID# _____	Attending MD, Dental, Allied Health ID# _____	Fellow, Resident, Rotating Resident ID# _____	Annual, 1st year, pastoral care ID# _____	Traveler, Other Title: _____ ID# _____

In the past year, have you:		
Is your primary department the Emergency Department?	☐ YES	☐ NO
Are you a resident, fellow or medical student?	☐ YES	☐ NO
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
Current or planned immunosuppression (Including HIV, receipt of an organ transplant, treatment with a TNF- alpha agonist, chronic steroids, or other immunosuppressive medication	☐ 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, sweats and/or fever >100.0 without alternative etiology	☐ YES	☐ NO
Chest pain	☐ YES	☐ NO
Difficulty breathing	☐ YES	☐ NO
Volunteered in a homeless shelter or jail	☐ YES	☐ NO
Had visitors from a foreign country stay with you	☐ YES	☐ NO
Temporary or permanent residence (for >1 month) in a country with a high rate of TB (ie: any country other than Australia, Canada, New Zealand, US and those in western/northern Europe)	☐ YES	☐ NO
Had close contact with someone who has infectious TB disease since your last TB test	☐ YES	☐ NO
If you answered yes to any of the above, please explain:		
Travel outside the United States in the last 12 months: ☐ I have not traveled outside the U.S. in the past 12 months ☐ Dates of Travel:_____		

☐ Locations: _____

☐ Duration of trip: _____

Have you ever had a positive TB Test?

☐ NO ☐ Yes, I had a positive Skin Test on _____ OR ☐ Yes, I had a positive TB Blood Test on _____

Year Year

Did you have a chest x-ray completed and reviewed by a radiologist? ☐ YES ☐ NO

Did you receive LTBI Treatment? ☐ No ☐ If yes, please describe:

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 _____

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

**This agreement shall be maintained in the files of the hosting department

WAIVER AND RELEASE OF MEDICAL LIABILITY

I, , (Student'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.

_____

Student's Signature

Student's Printed Name: Signature Date:

Student's Permanent Address:

Student's Email:

Student's Phone Number:

Dates at Children's:

Sponsoring

College/University:

Program/Discipline Name:

Sponsoring Professor's Printed Name: