

Participant Agreement:

As a participant in the CHI Health Student Experience program:

1. I understand the importance of maintaining the privacy of all confidential medical information.
2. I agree to maintain patient confidentiality.
3. I recognize that I may be exposed to potential risks as a result of this activity and will not hold CHI Health liable for any risks as a result of this activity.
4. I will not touch the patients. If I am allowed to observe a patient having a procedure, I understand the director or manager is to obtain the patient’s consent first.
5. I will not touch medical equipment.
6. I understand that I do not have medical record or chart access and will not have computer access.
7. I will not assist in feeding but may help deliver food.
8. I will not approach physicians about personal illness or medications.
9. I will dress professionally as outlined in the Dress and Grooming Standards.
10. I am subject to CHI Health drug testing policy. If I object, I will be asked to leave the premises immediately.
11. I understand CHI Health is not held responsible for any accident or injury that may occur on its premises while shadowing.
12. I understand that I am to leave all valuables at home.
13. I understand that any use of a cellular device is prohibited.
14. I will not perform my own personal care in the clinical setting (i.e. applying lip gloss, handling contact lenses, eating or drinking, brushing hair, etc.)
15. I will not be permitted in areas of contamination such as isolation rooms, soiled linen areas, neonatal intensive care, burn unit, behavioral and autopsy room.
16. I understand that I cannot participate in the program on days that I am ill. These include but are not limited to: fever, diarrhea, productive cough, rash, or open wound.
17. I understand that I am required to complete the online General Orientation *link above to CHI before participating in the student experience.
18. I understand that CHI Health will have the right to immediately terminate my participation in the Student Experience program if it is determined at the manger or supervisor’s discretion that I am not acting in the best interest of the patient or facility. In addition, the director or manager holds the right to terminate shadowing at any point if deemed necessary.

Student Experience Participant Agreement:

_____	_____	_____
<i>Name</i>	<i>Signature</i>	<i>Date</i>

Consent for Emergency Treatment:

In the case of an injury while participating in career exploration activities at CHI Health, I give my consent for CHI Health, its physicians, employees and agents to render emergency and other necessary medical treatment.

I, _____ (Name), release CHI Health, its physicians, employees and agents from any costs associated with rendering of treatment to the minor that is necessary in an emergency.

Signature

Date

Emergency Contact Information

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Parental/Guardian Participation Consent:

If is younger than 19, a parent or guardian's signature is required.

(Name) _____ has my permission to participate in the Student Experience offered by CHI Health. I have reviewed the terms of this confidentiality agreement with my child, stressing the importance of maintaining the privacy of all confidential medical information he/she may encounter during the course of his/her Student Experience. I recognize that Student Experience offers a significant benefit to my child in terms of first-hand exposure to potential career opportunities in the medical field. In consideration for this benefit, I agree to hold harmless and indemnify CHI Health from any liability arising from my child's failure to abide by CHI Health's policies concerning the privacy of confidential medical information.

Signature of Parent/Guardian

Date