HEALTH CAREERS CLUB

REGISTRATION FORM
2018-2019

DATE: _____

FIRST NAME: _____ **LAST NAME:** _____

DATE OF BIRTH: _____ **GENDER:** (circle) **M F ETHNICITY** (select one) **Hispanic Yes ☐ No ☐**

RACE (select all that apply) **☐American Indian/Alaskan Native ☐Asian ☐African-American/Black ☐Caucasian/White ☐Native Hawaiian/OtherPacific Islander ☐Other**

ADDRESS: _____ **CITY:** _____**ZIP:** _____

COUNTY: _____

HOME PHONE (_____**)**_____**-**_____ **CELL PHONE (** ____ **)**_____**-**_____

E-MAIL: _____**@**_____

HIGH SCHOOL: _____**GRADE LEVEL:** _____

EXPECTED GRADUATION YEAR: _____ **T-SHIRT SIZE: S M L XL**

Were you in this club last year? Yes ☐ No ☐ Have you ever job shadowed with AHEC? Yes ☐ No ☐

Parent/Guardian:_____
Name Emergency Number

Parent/Guardian:_____
Name Emergency Number

HEALTH CARE PROFESSIONS YOU ARE INTERESTED IN (list 3):

_____

_____

The following dress code will be strictly enforced. If you have any questions regarding this code, please contact NNAHEC before signing.

- We ask that the student dress in a manner that presents a look of professionalism.
- Students must dress modestly and neatly.
- Please avoid extreme dress, hairstyles and jewelry.
- Wear flat comfortable walking shoes – **no sandals, flip-flops, or open-toed shoes.** You are encouraged to wear clean tennis shoes and socks.
- Do not wear clothing that portrays suggestive or derogatory pictures and messages, including advertising of alcohol, tobacco, etc.
- Clothing should cover all undergarments and midriffs.
- No sleeveless tops/shirts/ blouses.
- Clothing should not be skin tight or revealing.
- The wearing of nose, eyebrow, tongue, lip and body jewelry is prohibited during Health Career Club activities.
- Body tattoos must be covered during Health Career Club activities.
- **During certain activities special dress codes will be enforced, information will be provided for these activities.**

I understand and agree to adibe by the Health Careers Club Dress Code.

Student Signature_____ Date _____

Parent Signature _____ Date _____

Photography/Video Release

I give permission to Northern Nebraska AHEC to use my child's picture for the purpose of promoting the Health Careers Club activities.

Parent Signature _____
Date _____

Norfolk, NE 68701
402-644-7253

AFFIRMATION AND RELEASE OF LIABILITY

(Student UNDER 19 years of age)

I, _____, the parent of legal guardian of _____, a minor child, hereby acknowledge that I am cognizant of and understand that there are inherent dangers in my child participating in the Northern Nebraska AHEC Health Careers Club, which includes, but is not limited to encountering experiences which may be relatively new and may be taxing on my child's senses and also being around an environment that has sick and injured patients.

In consideration of my child being allowed to participate in this program, I hereby assume all risk in connection with any of the above mentioned activities, situations and being present at any of the facilities where Northern Nebraska AHEC holds meeting or activities. I hereby give permission for my child to participate in the Northern Nebraska AHEC Health Careers Club and I hereby release Northern Nebraska AHEC, its administration, board of directors, employees, and agents from any and all liability related to my child's participation in the Northern Nebraska AHEC Health Careers Club.

I further state that I am the parent or legal guardian of my child, I am of lawful age, and I am competent to sign this Affirmation and Release of Liability form; that I understand the terms herein are contractual, and not a mere recital; and that I have signed this document as my own free act. I am fully informed of the contents of this Affirmation and Release of Liability, as I have read it before I have signed it.

_____ _____

Signature of Parent of Legal Guardian Date

FAITH REGIONAL
HEALTH SERVICES

Understanding of Hospital Confidentiality

(Required by Nebraska and U.S. Federal Law and Faith Regional Health Services Policy)
As an employee or associate (i.e. volunteer, student shadow, officer, intern, contract) of Faith Regional Health Services, I, the undersigned, hereby acknowledge that I have read and understand the Faith Regional Health Services' policy on confidentiality of personal health information as described in the Confidential Information Policy, which is in accordance with Nebraska and Federal law.

I also acknowledge that I am aware of and understand Faith Regional Health Services' policies regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information.

I understand that I have the responsibility for maintaining strict confidentiality of information shared with me or acquired by me as a part of my routine duties and access at Faith Regional Health Services. Any patient information, computer passwords, confidential information about an employee, physician, or management and any and all financial information regarding Faith Regional Health Services that is made available to me as an associate or employee of Faith Regional Health Services is for my professional and authorized use only. I understand that such information may be discussed only as needed to perform the duties and responsibilities of my position.

In consideration of my employment/association with Faith Regional Health Services, and as an integral part of the terms and conditions of my employment/association, I hereby agree, pledge and undertake that I will not, at any time during my employment/association with Faith Regional Health Services, or at any time after my employment/association ends, access or use personal health information, or reveal or disclose to any persons or entities within or outside of Faith Regional Health Services, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with all applicable legislation, corporate and departmental laws, rules, regulations or policies governing the release of information.

I understand that my obligations outlined above will continue after my employment/association with Faith Regional Health Services ends and, **I further understand** that my obligations concerning the protection of the confidentiality of personal health information relate to all personal health information, that I have acquired through my employment/association with Faith Regional Health Services or within any of the healthcare facilities owned or managed by Faith Regional Health Services.

I also understand that unauthorized use or disclosure of confidential information will result in corrective action up to and including, but not limited to termination of employment with Faith Regional Health Services, the imposition of sanctions or fines pursuant to Nebraska and Federal laws, and a report to any and all of my professional regulatory bodies.

_____ _____

Signature Date