



STUDENT INFORMATION SHEET

Please Print

Please check one: Individual Under 19 yrs of Age Individual 19 years and Over

NAME: _____ DOB: _____ Age: _____

HOME ADDRESS: _____ CITY, ZIP: _____ COUNTY NAME: _____

HIGH SCHOOL HOME PHONE: _____ or COLLEGE: _____

STUDENT EMAIL ADDRESS: (if checked) _____

GRADE _____ INSTRUCTOR/ Or YEAR: _____ COUNSELOR/ADVISOR: _____

RACE: (Check One) Caucasian __, African American __, Native American __, Hispanic __, Asian __, Other __, Prefer to not answer __ GENDER: Female __, Male __

AREAS YOU WISH TO SEE (Number 1-3 in order of preference) at hospital or community sites

- | | | |
|--|--|---|
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Medical Laboratory | <input type="checkbox"/> Podiatry (feet) |
| <input type="checkbox"/> Business Office | <input type="checkbox"/> Medical Records not at this time | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Ophthalmology, Optometry (eyes) | <input type="checkbox"/> Medical Office Assistant | <input type="checkbox"/> Physical Therapy Assist. |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Nursing-hospital | <input type="checkbox"/> Physician: Specialty _____ |
| <input type="checkbox"/> Dental Hygiene | <input type="checkbox"/> Nursing- Long Term Care | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Nutrition (Dietetics) | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Hospital Administration | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Recreational Therapy |
| <input type="checkbox"/> Hospital Ministry | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Respiratory Therapy |
| | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Social Services |

WHY DO YOU WISH TO SHADOW IN THESE AREAS?

DATE YOU WISH TO SHADOW (Please list 3 dates at least two weeks from now in order of preference)

1. _____ 2. _____ 3. _____

Number of shadowing hours desired: _____

EMERGENCY NOTIFICATION:

NAME: _____ PHONE: _____

Return the following completed forms:

Student Information Sheet, Dress Code, Release of Liability, Confidentiality, and Health Assessment forms to:

Northern Nebraska AHEC, 110 North 16th St, Ste #2, Norfolk, NE 68701

Go to www.nnaheec.org under Job Shadowing, "Looking for Confidentiality & HIPAA Training" for quiz.

I submitted my test on this date ___/___/___.



AFFIRMATION AND RELEASE OF LIABILITY
(Student UNDER 19 years of age) (19+ on second page)

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 Fremont Area Medical Center and Northern Nebraska AHEC Student Shadow Program, 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 of Fremont Area Medical Center or Northern Nebraska AHEC. I hereby give permission for my child to participate in the Fremont Area Medical Center and Northern Nebraska AHEC Student Shadow Program and I hereby release Fremont Area Medical Center and Northern Nebraska AHEC, its administration, board of directors, employees, and agents from any and all liability related to my child's participation in the Fremont Area Medical Center and Northern Nebraska AHEC Shadow Program.

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



AFFIRMATION AND RELEASE OF LIABILITY

(Student 19 years of age or OLDER)

I, _____, hereby acknowledge that I am cognizant of and understand that there are inherent dangers in my participating in the Fremont Area Medical Center and Northern Nebraska AHEC Student Shadow Program, which includes, but is not limited to encountering experiences which may be relatively new and may be taxing on my senses and also being around an environment that has sick and injured patients.

In consideration of my 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 of Fremont Area Medical Center or Northern Nebraska AHEC. I hereby release Fremont Area Medical Center and Northern Nebraska AHEC, its administration, board of directors, employees, and agents from any and all liability related to my participation in the Fremont Area Medical Center and Northern Nebraska AHEC Shadow Program.

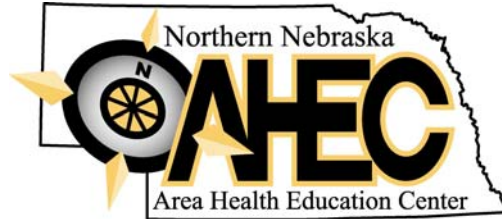
I further state that I am at least nineteen (19) years of age and I am competent to sign this Affirmation and Release of Liability form; that I understand the terms herein are contractual, and not a mere recital; and that I have signed this document as my own free act. I am fully informed of the contents of this Affirmation and Release of Liability, as I have read it before I have signed it.

Student Signature

Date



450 East 23rd Street
 Fremont, NE 6825
 (402) 727-4007



NORTHERN NEBRASKA AHEC
 110 North 16th Street, Suite #2
 Norfolk, NE 68701
 (402) 644-7253 FAX (402) 644-7254

NORTHERN NEBRASKA AHEC SHADOWING DRESS CODE

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

- We ask that the student dress in a manner that presents a look of professionalism.
- Participants must dress modestly and neatly with shirt tucked into pants.
- Please avoid extreme dress, hairstyles and jewelry.
- Do not wear clothing that portrays suggestive or derogatory pictures and messages, including advertising of alcohol, tobacco, etc.
- Clothing should cover all undergarments.
- No sleeveless blouses, shirts or tops.
- Clothing should not be skin tight or revealing.
- The wearing of nose, eyebrow, tongue, lip and body jewelry is prohibited during shadowing hours.
- Body tattoos must be covered during shadowing hours.
- Wear flat comfortable walking shoes – no sandals or open-toed shoes.
- Wear dress slacks – NO BLUE JEANS please.
- Students shadowing Physical Therapy or Occupational Therapy are asked to wear polo shirts and dress slacks.
- Nursing students are required to wear tennis shoes and socks.

The Shadowing Director is responsible to evaluate the dress and appearance of all students. If a student is not dressed appropriately, the student’s parents will be contacted to bring appropriate attire or remove the student from the program.

I understand and agree to abide by the Northern Nebraska AHEC Shadowing Dress Code.

Student Signature _____ Date _____

(If under 19 years of age)

Parent Signature _____ Date _____

Adopted/Approved By **Fremont Area Medical Center**

 CEO/President

 Date



Confidentiality, Security & Information Services Job Shadow Agreement

As student at Fremont Area Medical Center (FAMC), and as a condition of my **job shadowing** experience, I agree to the following:

Confidentiality

1. I understand that I am responsible for complying with the HIPAA policies, which were provided to me.
2. I will treat all information received in the course of my shadowing experience, which relates to the patients, as confidential and privileged information. I understand that FAMC has a zero tolerance level for breaches in confidentiality and that FAMC will discipline as appropriate including the termination of my job shadow experience.
3. I will not access patient information unless I have a need to know this information in order to perform my role.
4. I will not disclose information regarding FAMC patients to any person or entity, other than as necessary to perform my role, and as permitted under the HIPAA policies.

Computer Access and Security

5. I will not log on to the computer systems that currently exist or may exist in the future.
6. I will not take patient information from the premises of FAMC in paper or electronic form without first receiving permission from the Privacy officer.
7. I will not bring unauthorized software and load it on a FAMC computer.
8. I understand that the MIS department will approve software purchased for use at FAMC and MIS will be responsible for the installation and registration of all software.
9. Upon cessation of my job shadowing experience with the provider, I agree to continue to maintain the confidentiality of any information I learn while at FAMC and agree to turn over any keys, access cards, or any other device that would provide access to FAMC or its information.

Student Signature

Date

Job Shadow Experience

Health Assessment Screen



Print Student Name	Print Name of School

Check (√) that all three items have been reviewed.
Student and School Nurse must sign form.

Current and up to date on all Immunizations - All required immunizations have been administered prior to my Job Shadow experience at Fremont Area Medical Center.

Student will be **free of communicable diseases** when observing at FAMC.

Example: elevated temperature, eye infection (conjunctivitis and pink eye), diarrhea, strep throat, Hepatitis A (jaundice), Measles, Mumps Whooping Cough (Pertussis), Rubella, Scabies, skin lesions that are open and draining, Chicken Pox, Tuberculosis (night sweats, weight loss, fatigue, loss of appetite, coughing up blood).

The student will report such signs and symptoms to FAMC's Clinical Education Specialist (402-727-3769) should they develop while onsite at FAMC.

If the participant develops a communicable disease within seven (7) days after observing at FAMC, the individual shall report the situation to the Clinical Education Specialist (402-727-3769) at FAMC.

Student Signature: _____ Date: _____

School Nurse: _____ Date: _____