CENTRA Demographic Form for Student Short-term Observational Experiences

Please complete as appropriate.

Student Name*	
Address (street, city, state, zip)*	
Last four numbers of SSN & Birth Date*	
Is student under 18 years of age? *	____ No ____ Yes (Please attach signed Parental Permission form)
Home Phone*	
Alternate Phone	
E-mail Address*	
Emergency Contact Name & Relationship*	
Emergency Contact Phone*	
Name of School/ College/University	XLR8 STEM Academy
Graduate/Undergraduate*	____ Undergraduate ____ Graduate __X__ High School ____ Other (_____)
Major/ Observation Focus*	School Field Trip
• Is this a short term shadowing experience? (less than 12 hours)	__X__ Yes (answer b) ____ No
Facility/CMG Practice/Department where observation will occur*	Lynchburg General Hospital
Who are you shadowing at Centra?*	
Hours scheduled to shadow?	
Date Scheduled to shadow*(may be approximate)	February 2022
Uniform Requirements	Business Casual

Below for Centra use Only	
Human Resources (if applicable) Background Check	Date: _____ Time: _____ Signature:_____
Health Works- Health Forms Sent	Date: _____ Signature: _____
General Orientation (eHealthcareIT)	On-line Orientation Required: ___ Yes __X_ No
Forms Received in Student Affairs Dept.	Date:
Name person who collected forms	

Centra Confidentiality Agreement No Computer Access

Effective security and confidentiality is a team effort involving the participation and support of every Centra Health employee and affiliate who deals with information and/or information systems. It is the responsibility of all users to know these guidelines and to conduct their activities accordingly.

Centra Health's policy is that all information is confidential, including, but not limited to patient diagnoses or courses of treatment, physician or other professional activities, Centra Health procedures, or financial and operating statistics. This policy applies whether the information is obtained through verbal, written, or electronic means. Information is to be accessed only on a "need to know" basis. The term "need to know" means the information is essential for performance of work responsibilities at Centra Health.

By my signature, I acknowledge that I have read the Confidentiality Policy and I understand the content and importance of these policies. I accept the responsibility that is placed on me as a Centra Health employee or affiliate to comply with these obligations and agree to abide by the policies of Centra Health as outlined in in the online orientation. I understand and agree that my obligation to maintain the confidentiality and security of the information shall continue after my relationship with Centra Health ends. I will contact Corporate Compliance if I have questions about policies or to request a paper copy of policies.

Signed: _____ Date: _____

Typing your name on the line above constitutes an electronic signature under Virginia Code 59.1-485.

Rules and Policies

By signing below, the intern/student understands that failure to follow the rules and policies of Centra will result in the termination of their learning experience. The following is not permitted:

1. Acceptance of money or valuable gifts from patients, families, vendors, or other work related parties is not allowed.
2. Being under the influence or possessing drugs or alcohol.
3. Deliberate destruction or misuse of property.
4. Fighting or other disorderly conduct.
5. Insubordination or failure to carry out supervisor instructions.
6. Leaving work area without permission.
7. Theft, fraud, or misappropriation of property.
8. Threatening, intimidating or coercing others by words or deeds, or use of vile or abusive language.
9. Unauthorized accessing, discussions, and/or release of confidential information concerning patients or employees.
10. Abuse or inconsiderate treatment of patients.
11. Gambling.
12. Possession of weapons.

***Complete copies of all policies referenced above are available from Corporate Compliance*

Observer Conduct

1. Observers will follow the departmental dress code.
2. Centra "Student" ID badges are not to be worn when students are observing outside of clinical rotations.
3. Observers will not use personal cell phone for taking pictures, calls or texting in patient or public areas or while observing patient care. Observers may carry a cell phone for emergency use only.
4. The Observer will not participate in any hands-on or direct patient care activities.

Signature: _____ Date: _____

Typing your name on the line above constitutes an electronic signature under Virginia Code 59.1-485.

Print Name: _____

Parental Permission Form for Students Under 18 Years of Age

I have read the Rules and Policies pertaining to Observers at Centra, and I grant permission for my son or daughter, _____, to participate in a learning experience at Centra. I am aware that the time spent is in a health care environment and its inherent risks.

Signature of Parent/Guardian: _____

Typing your name on the line above constitutes an electronic signature under Virginia Code 59.1-485.

Print Name of Parent/Guardian: _____

Date: _____

Healthworks
125 Nationwide Drive
Lynchburg, Virginia 24502
Phone: (434) 200-6939
Fax: (434) 200-6934

Certificate of Health
Short Term Observation Education Experience

I certify that I do not have any health problems that may pose a risk to hospital patients or staff. I am free from contagious or infectious disease, do not have any symptoms of illness and am feeling well.

Signature: _____

Date of Birth: _____

Social Security Number: _____
(Required-Used for record keeping and compliance tracking purposes only)

Parental Signature: _____

Centra Site/Campus: Centra Facilities

Centra Preceptor: Mackenzie Case

Start Date: _____ **End Date:** _____

You must provide a record of a TB Skin Test (TST) that has been administered and read within the last 12 months and remain current during your observation time at Centra.

Thank you,
HealthWorks/Centra Employee Health

Nurse Signature: _____

Date : _____

Short term observation is defined as twenty (20) hours or less.

HealthWorks

Affiliating Health Record

☐ **Student (0005)** ☐ **Volunteer (0003)**

Start Date: _____ **End Date:** _____

School/College: STEM Academy

Centra Site/Campus: Centra Facilities

Centra Preceptor: Mackenzie Case

Name: _____

Email Address: _____

Date of Birth: _____

Social Security Number: _____
(Required-Used for record keeping and compliance tracking purposes only)

Address: _____
(Street) (City) (State) (Zip)

Phone: _____
(Home or Cell)

Signature: _____

OFFICE USE ONLY-PLEASE ATTACH IMMUNIZATION RECORDS

MMR Vaccination & Booster	**#1**		**#2**		Titer Pending:	☐	
Varicella (Chicken Pox) Vaccine	**#1**		**#2**		Titer Pending:	☐	
Hepatitis B Vac:	**# 1**		**# 2**		**# 3**	CAT III ☐	Titer Pending: ☐
Influenza Vac:		**Tetanus/Diptheria/Pertussis Vaccine:**					
Last TST Date:		**Result Date:**					
Healthworks Nurse Signature				Date:			

HEALTHWORKS
Phone (434) 200-6939
Fax (434-200-6934

HealthWorks

Step #1 ☐ **Step#2** ☐ **Required Update** ☐ **Exposure** ☐

PLEASE REMEMBER TO MEET THE MANDATORY REQUIREMENT FOR EMPLOYMENT
THIS FORM MUST BE RETURNED TO HEALTHWORKS

NAME: _____ **POSITION:** _____

DEPT: _____ **Date of Birth:** _____

Are you experiencing any of the following tuberculosis symptoms at this time?

☐ Loss of appetite ☐ Chest pain ☐ Fever (generally at night) ☐ Productive cough

☐ Unexplained weight loss ☐ Night Sweats ☐ Fatigue ☐ Hemoptysis

Please answer the following questions:

Do you have a fever at the present time?	☐ YES ☐ NO
Has BCG vaccine (Vaccine is **NOT** routinely given in the USA) ever been administered to you?	☐ YES ☐ NO
Are you taking steroids or cancer drugs?	☐ YES ☐ NO
Have you had a viral infection within the last 8 weeks due to (Measles, Mumps, Influenza, etc)?	☐ YES ☐ NO
Have you had a live virus vaccination within the last 8 weeks (Measles, Mumps, Polio, Influenza mist, Yellow fever, Small Pox)?	☐ YES ☐ NO
Have you ever had a POSITIVE reaction to a Tuberculin Skin Test?	☐ YES ☐ NO

I have answered the above questions to the best of my knowledge. I understand that the above questions will only be used to determine if a TST can be administered. I consent to TST administration if not contraindicated due to past positive reactions.

Signature: _____ Date: _____

SELF READING OF THIS TB SKIN TEST IS NOT ACCEPTABLE

OFFICE USE ONLY

Date Given: _____ Site: _____ Date Read: _____

Manufacturer: ☐ JHP ☐ Sanofi Pasteur Result: _____ MM

Lot#: _____ Exp. Date: _____ Reader Signature: _____

May be read by any RN/LPNIF NO REACTION****

Administered By: _____

READ AFTER _____ / _____ **AND BEFORE** _____ / _____

DATE TIME DATE TIME

FOR ANY SITE REDNESS OR INDURATION REPORT IMMEDIATELY TO HEALTHWORKS

Site care: Blot gently, **NO** lotion/cream to area, **NO** scrubbing or scratching, **OK** to shower/swim

Date:

To: Parent/Guardian

Subject: Consent for Vaccination/Testing

I give permission and consent to the Healthworks office physician or nurse to administer examinations, treatment or testing that is deemed medically necessary to meet the CDC/OSHA requirements for Healthcare facilities including the administration of the following tuberculosis skin test and/or vaccination(s) to my child.

- ☐ TDAP
- ☒ TB skin test
- ☐ Hepatitis B
- ☐ MMR (Measles, Mumps & Rubella)
- ☐ Varivax (Chicken pox)
- ☐ Flu Vaccine

_____
Name of Child

_____ _____
Parent/Guardian Signature Date