Saint Luke's
HEALTH SYSTEM

Authorization and Release for Student Participation

STUDENT'S NAME (Please Print): _____

EMERGENCY CONTACT: _____ **TEL:** _____

STUDENT'S RESPONSIBILITIES

I am a student of _____ College/University participating in a rotation at Saint Luke's Health System from_____ to _____. I acknowledge that the System has made its facilities available to me for educational purposes. I have read, fully understand and agree to abide by the information provided in the Student Guidelines. I have taken and passed the CNE/KCANE Orientation Competency Exam or the Saint Luke's Health System Information Security and HIPAA tests. I acknowledge that I have turned in to my College/University proof of vaccinations and other paperwork as required by individual program. I further agree to comply with all instructions of the physicians, nurses and other Hospital and System staff and to abide by the System's policies and procedures. I agree to engage in only those activities that are a part of and authorized under my educational program at the System.

I have documented evidence of a negative PPD Mantoux TB skin test or negative chest x-ray, if TB skin test is positive obtained within the last 12 months stating that I am free from active tuberculosis. I attest I have not knowingly had contact with anyone with active Tuberculosis (TB). I can show evidence of a current flu vaccine (Oct – May). If I will have contact with blood or other body fluids at the Hospital, I have documented evidence of immunity to Hepatitis B (completed Hepatitis B vaccine series or positive Hepatitis B antibody titer/screen or evidence that the vaccine was offered, and waiver was signed by me). I have documented evidence of immunity to measles (rubeola), mumps and rubella (vaccination or antibody titer/screen).

I agree to keep all patient information confidential. I hereby agree, pledge and undertake that I will not at any time, during my association with Saint Luke's Health System, or after my association ends, access or use protected health information, or reveal or disclose to any persons within or outside the Saint Luke's Health System, any protected health information, except as permitted or required by law. I further understand that my obligations concerning the protection of the confidentiality of protected health information relate to all protected health information acquired through my association with Saint Luke's Health System. I also understand that unauthorized use or disclosure of such information could result in the imposition of fines pursuant to applicable state, or federal regulations and a report to my professional regulatory body. I agree that accessing health information is strictly done only if required to provide direct patient care. Access to any other information, including but not limited to, my own record or that of family, friends, or acquaintances is strictly prohibited. I understand that my use of the SLHS network, including the EMR is monitored and failure to comply with these guidelines can result in expulsion from the clinical environment.

I hereby release the System and its officers, employees and agents and any other persons performing services at the System, from responsibility for any injury or ill effects, physical as well as emotional, which may result from my participation in the educational activity or from my presence in the System.

_____ _____

STUDENT SIGNATURE **DATE**