Children's Mercy KANSAS CITY

Completion of this document is REQUIRED of Observer

Attachment A: Agreement for Observation

I am requesting permission to observe in _____(list area of interest) at Children's Mercy.

My observation experience objective is (choose one):

_____ Completing as part of a job application process
_____ Applying to a healthcare program (University, College, etc)
_____ Considering a possible career in healthcare
_____ Desire an observation in a pediatric facility. No clinical rotations/ opportunities through school
_____ Other, please explain:_____

I understand that my observation experience at The Children's Mercy Hospital will not exceed two days in duration for a total of 8 hours. Various time frames will be considered; however, will not exceed the 8-hour total observation experience.

I agree to conform to all Hospital policies and procedures during the time I spend at Children's Mercy Hospital. I agree to take direction from the Hospital program director and his/her designees.

I understand that for my safety and the safety of the pediatric patients in this healthcare setting, it is important for me to complete the required Health Information Form.

I understand that despite all reasonable safety precautions, healthcare environments present a risk of exposure to communicable diseases. I agree to abide by the Standard Precautions procedures. If I am pregnant or think I might be, I agree to inform the person supervising my observation BEFORE I begin my experience at Children's Mercy Hospital.

I understand that emergency medical assistance is available if needed but that I am responsible for any related expenses and for my own health insurance. I also understand that the Hospital is not providing insurance coverage for me, including professional liability, general liability insurance, or workers compensation coverage.

I understand that the Hospital has the right to terminate my observation at any time and that I cannot participate (touch patients, treat, etc.) in patient care.

In consideration for the opportunity to complete my experience at The Children's Mercy Hospital, I hereby release The Children's Mercy Hospital, its officers, director, trustees, and members, employees, and agents from any claim, damage or liability related to my experience at The Children's Mercy Hospital.

I understand that if I have any questions or concerns that I will discuss those with the Hospital program director and his/her designees. I also understand that I can report concerns through the Corporate Compliance Hotline 877-900-2279.

I have reviewed the Hospital "Information about Children's Mercy for Non-Employees, Vendors, and Affiliates" and agree to abide by these requirements.

_____	_____	_____
Observer's PRINTED Name	Observer's Signature	Date

If observer is under 18 years of age, legal guardian is required to sign below.

_____	_____	_____
Legal Guardian's PRINTED Name	Legal Guardian's Signature	Date

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OBSERVER'S INFORMATION (PRINT Legibly)

Observer's Name: _____
First Middle (full name) Last

Date of Birth (MM/DD/YEAR): _____/_____/_____

Home Address:_____

Name of Observer's Educational Institution: _____

E-mail: _____

Telephone:(cell)_____-_____-_____ (work) _____-_____-_____

Social Security Number (put N/A if no Social Security Number): _____

Emergency Contact Name:_____ Cell Number:_____-_____-_____

Emergency Contact's Relationship to Observer: _____

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Health Information Form:

I understand that for my safety and the safety of the pediatric patients in this healthcare setting it is important for me to complete the following health history information.
I must **provide documentation** of the following:

Chickenpox (Varicella): (Vaccination OR Positive IgG Titer)	Two Varivax vaccines (at least 28 days apart)	#1 ____/_____/_____	#2 ____/____/____	
	OR serological proof of immunity (positive varicella IGG titers)	____/_____/_____		
MMR (Measles, Mumps and Rubella): (Vaccination OR Positive IgG Titer)	Two MMRx vaccines (at least 28 days apart)	#1 ____/_____/_____	#2 ____/____/____	
	OR serological proof of immunity (positive IGG titers for each)	____/_____/_____		
TB: (Skin Test OR IGRA within last 12 months)	Skin test (within last 12 months)	____/_____/____ result: _____mm		
	OR IGRA blood assay test (e.g. Quantiferon Gold or T Spot) (within last 12 months)	____/_____/____ result: _____		
Tetanus/diphtheria/ acellular pertussis- (Tdap): (Adult formulation-Adacel or Boostrix) (usually given around age 11-12 years of age.)	_____/_____/_____			

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Hepatitis B: (Immunization AND Titer OR waiver)	#1 _____/_____/_____	#2 _____/_____/_____	#3 _____/_____/_____	***And*** Titer ___/____/___ result: _____
	OR Documented Waiver Signed on: _____/_____/_____			
Influenza: (Proof of vaccination during the flu season as defined by Children's Mercy.)	_____/_____/_____			
Information about Children's Mercy for Non-Employees, Vendors and Affiliates Brochure: (Please contact the Designated Student Coordinator for access to this brochure.)	Attestation Statement signed and received: _____/_____/_____			
COVID-19: (Not required. Recommended)	#1 _____/_____/_____ #2 _____/_____/_____ Manufacturer: _____	Additional Doses: _____/_____/_____ Manufacturer: _____ _____/_____/_____ Manufacturer: _____ _____/_____/_____ Manufacturer: _____		
Any additional vaccination requirements: (Please contact the Designated Student Coordinator for more information.)				