

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

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: _____

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.)	____/____/____			

	#1 ____/____/____	#2 ____/____/____	#3 ____/____/____	<u>And</u> Titer ____/____/____ result: _____
Hepatitis B: (Immunization AND Titer OR waiver)	OR Documented Waiver Signed on: ____/____/____			
Influenza: (Proof of vaccination during the flu season as defined by Children's Mercy.)	____/____/____			
COVID-19: (Children's Mercy does not allow for an exemption for observations)	Show documentation of: <ul style="list-style-type: none"> • 2 doses of Pfizer or Moderna administered from 2020 to May 31, 2023. • 1 dose of Johnson & Johnson administered from 2020 to Today • 1 dose of Pfizer/Pfizer BioNTech or Moderna administered after June 1, 2023 	Manufacturer: _____ #1 ____/____/____	#2 ____/____/____	
Any additional vaccination requirements: (Please contact the Designated Student Coordinator for more information.)				
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: ____/____/____			