Nurse Camp Required Documentation

All required forms and permission slips must be signed and completed prior to Orientation.

Print and sign the following forms and bring to your orientation session. To save on printer ink, most of your schools allow printing of these forms on your school campus. Note: Parent/guardian signature is required on most forms

1. Nurse Camp Agreement Form
2. Medical Authorization
3. Field Trip Permission Slip
4. Release and Waiver
5. Consent for Photography/Videotape
6. Internet/Intranet Acknowledgement
7. Confidentiality Statement
8. Pacific Lutheran University Forms (x2)
MultiCare Health System

NURSE CAMP AGREEMENT FORM

* Please complete and bring with you to your Nurse Camp Orientation.

Nurse Camp Student Name:_________________________  Today’s Date:____________________

* I understand that my signature indicates:

I will notify the camp coordinators if I decide not to attend or cannot attend for any reason.

I will attend all 5 days of camp, July 9-13, 2018; contacting the Director by 8:30 am if ill or unable to attend any day of camp.

I agree to a background check.

I will bring a lunch and water for each day of camp.

I will behave respectfully as a professional at all times during the MultiCare Nurse Camp 2018. I understand I am representing MultiCare Health System, and will uphold all policies, protocols and guidelines.

While handling needles and other medical equipment, I will listen closely to instructions and follow all safety protocols, including safe disposal of needles and sharp objects. I will not keep any equipment used during practice exercises, unless told that I may do so by the instructor.

If for any reason, I don’t adhere to these conditions, I understand my spot in Nurse Camp may be lost.

Student Signature:_________________________________________ Date:____________________

Parent/Guardian Signature:________________________________________ Date:____________________
MEDICAL AUTHORIZATION FORM

Should it become necessary for my child to receive medical attention or treatment while participating in the MultiCare Nurse Camp, I hereby give permission to MultiCare personnel to use their best judgment in obtaining medical service for my child. I further give the selected physician permission to render whatever medical treatment he or she deems necessary and appropriate. Permission is also granted to release necessary emergency contact/medical history to the attending physician as needed.

Student’s name: ________________________________________________________________
Address: ______________________________________________________________________
Date of Birth: __________________________________________________________________
Home Phone: __________________________________________________________________
Name of Parent or Guardian: ______________________________________________________
Daytime Phone Contact for Parent or Guardian: _______________________________________
Contact other than Parent or Guardian: _____________________________________________
Relation to Student: ____________________________ Phone: _______________________
Family Doctor: ________________________________ Phone: _______________________
Preferred Hospital: ______________________________________________________________
Address: ______________________________________________________________________
Hospital Phone: ________________________________________________________________
Does your child require any special accommodations due to medical limitations, disability, dietary constraints or other restrictions?    Yes _____ No _____
Please explain: __________________________________________________________________

I hereby agree to all of the above authorizations and restrictions.

__________________________________________ ______________________________
Signature of Parent or Guardian    Date

OR:

☐ I do not wish to give a medical release.
☐ I do not wish to release my child’s emergency information to any necessary medical providers or to the workplace in the event of a medical emergency.

__________________________________________ ______________________________
Signature of Parent or Guardian    Date
Nurse Camp 2018
Field Trip Permission Form

Student Name ____________________________________

Date: July 9-13, 2018

Purpose: During Nurse Camp 2018, students will be traveling to Tacoma Community College, Pacific Lutheran University, Pierce College (Puyallup Campus), Green River Community College, Clover Park Technical College, Allenmore Hospital, Good Samaritan Hospital, and/or Auburn Medical Center to observe nursing and allied health college and university programs and participate in hands-on educations and activities, including job shadowing medical professionals.

Trip Information

Destination: One or more of the following colleges/universities, or medical facilities: Tacoma Community College, Pacific Lutheran University, Pierce College (Puyallup Campus), Green River Community College, Clover Park Technical College, Allenmore Hospital, Good Samaritan Hospital, Auburn Medical Center.

No. of students: Maximum 30 per bus

Academic Focus: Nursing and Allied Health Career Programs and Job Shadows

Transportation: Durham Transportation (school bus), MultiCare shuttle (van), Puyallup Schools Transportation (school bus), Auburn Schools Transportation (school bus)

Supervision: Will be provided by MultiCare staff, Nurse Camp Counselors and Volunteers

Student Agreement

While participating in Nurse Camp…A Journey Into Nursing I will accept responsibility for maintaining good conduct and appearance and I will follow directions at all times.

______________________________   _______________________
Student Signature             Date

Parent/Guardian Permission

I give permission for _____________________________________ to participate in the field trips as part of the 2016 Nurse Camp…A Journey Into Nursing activities and educational experiences as described above.

______________________________   _______________________
Signature, Parent or Guardian            Date
Volunteer Services
Consent for Photography/Videotape

I authorize MultiCare Health System (MHS), its employees and its affiliates, to permit MHS or any media representative designated by MHS, to take and use photographic images, including photographs and videotape, of the undersigned for use in any internal or external print (video or web), television and/or other media, for purposes of documentation, public relations, publicity, advertising and/or promotion of MHS and/or its affiliate organization.

I also authorize MHS, its employees and affiliates, to release my name if, in their sole discretion, it is necessary for the purpose set forth above.

I understand that MHS will retain the ownership rights to the photographs, videotapes, digital or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and they will be kept for the time period required by law or outlined in MultiCare Health System’s policy.

The undersigned hereby releases MHS, its affiliates, employees and agents from all legal liability for loss or damages resulting from the taking or use of photographs or video, or for subsequent use for any media.

Name of Volunteer (Please Print) ____________________________ Date of Birth __________

Signature of Volunteer __________________________________________ Date __________

Department __________________________________________________ Work Phone Number __________

Location ___________________________________________________

☐ For Internal Use Only

Signature ___________________________________________________________
RELEASE AND WAIVER

I wish to participate in shadowing opportunity at MultiCare Health System. I understand and appreciate that being in a hospital environment raises certain risks. I am aware that I could sustain certain injuries at the Hospital while shadowing. Having read and received information regarding the Hospital’s safety, security, and general hospital orientation programs, I acknowledge that I am voluntarily coming to the Hospital with full knowledge of the risks and dangers involved, and I agree to accept any and all risks of injury to me.

I agree to assume all risks in connection with my shadowing experience at the Hospital and release and hold harmless MultiCare Health System – Tacoma, Washington, Hospital and their employees, officers, directors, and members who, through their negligence or any other cause, might otherwise be liable to me.

I intend by this Release and Waiver to release, in advance, and to waive my rights and discharge all of the persons and entities mentioned above from any and all claims for damages for personal injury or property damage which I may have, or which may hereafter accrue to me, as a result of my presence at Hospital for purposes of shadowing. I acknowledge that I am solely responsible for my personal health and safety and will not engage in any activities that subject me to undue risk.

I have carefully read this Release and Waiver and fully understand its terms. I understand that this is a release of liability and that I am signing it on a voluntary basis.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING.

Applicant Signature
Date

If Under 18, please complete the Consent to Participate:

Consent to Participate

The applicant has my permission to participate in a job shadow health care experience with MultiCare Health System. I will assist her/him in following the rules and regulations established to make this program successful.

Parent/Guardian Signature
Date
Volunteer Services
Internet/Intranet Acknowledgement

As a Volunteer of MultiCare Health System, ____________________________,
Recognize and understand that e-mail, internet and electronic files systems are
to be used in accordance with the terms and conditions of MHS Internet, E-mail
and Electronic File Access policy.

I understand that use of this equipment for private purposes other than
appropriate incidental personal use is strictly prohibited. I agree not to access a
file or retrieve any stored communication other than as authorized.

I am aware that MultiCare Health System reserves and will exercise the right to
review audit, intercept, access and disclose all matters on the e-mail system at
any time, with or without employee notice, and that such access may occur
during or after working hours.

I am aware that use of MHS-provided password or code does not restrict MHS’s
right to access electronic communications.

I am aware that violations of this policy may subject me to disciplinary action, up
to and including discharge from my volunteer status.

I have read and understand MultiCare Health System’s policy regarding Internet,
E-mail and Electronic File Access.

Signature: ___________________________________________ Date: ________________

Print Name: _______________________________________________
Volunteer Services
Confidentiality Statement

I understand the principle of confidentiality is basic to the maintenance of professional ethics and community respect. As a participant in MultiCare Health System’s volunteer program, I assume the ethical responsibility of holding all information obtained directly or indirectly concerning patients, doctors, staff, or other representatives of MultiCare as absolutely confidential. Information of a private or sensitive nature: medical record information, employee personnel records and system, facility or agency operating and financial data are also absolutely confidential. I will not actively seek to obtain any information considered to be confidential.

Furthermore, I understand that intentional or involuntary violation of our confidentiality policy will result in termination and punitive action including possible fine or even imprisonment.

Signature: _________________________________ Date: __________________

Print Name:________________________________________________________________________
Activity Participation & Medical Release Form

Full Name: ___________________________ Social Security Number: ____________
Birthdate: ____________________________
Name of Activity/Program: ____________ Date(s) of Activity: ____________ Location: Pacific Lutheran University

In consideration of my application to participate in a voluntary activity/program at Pacific Lutheran University (PLU), I agree to the information below.

I understand that participating in a voluntary activity/program at PLU involves risk. These risks are identified in the following categories:

Learning Environment: I understand that participating in a learning environment involves some risk. I will be moving from location to location on campus and/or in other locations, and learning within facilities at PLU and/or elsewhere. This involves risks and the potential of injury. These risks vary depending on innumerable factors. Injury can occur as a result of equipment failure, weather, acts of other participants or third parties, lack of supervision, or disease. Every type of injury could occur. This may include broken bones, chemical exposure, back or brain damage, death or dismemberment.

Active Participation: I understand that some of my experience at PLU may include active participation, athletic or aerobic activity. Participation in these activities requires rigorous exercise under conditions which are sometimes dangerous. Injuries to the participant can occur in many foreseeable and unforeseeable ways. Injuries can occur as a result of equipment failure, poor surface and/or field conditions, lack of proper supervision and the negligence of other participants (including but not limited to teammates, opponents, spectators, or officiating personnel). They can occur during periods of free time, strength training exercises, during practices or at athletic events themselves. Injuries can occur even if you, your teammates and opponents are physically fit and participating according to the rules of your chosen sport. They can also occur because you, your teammate or opponent is not physically fit or does not abide by the rules. Every type of injury could occur. This may include broken bones, ligament tears, back or brain damage, death or dismemberment.

Travel & Accommodations: I understand that part of my experience at PLU may include travel to or from event locations, overnight or daytime accommodations. These activities involve risk and the potential of injury. This can occur due to equipment failure, vehicle failure, accidents, facility malfunctions, negligent operation and/or supervision by an agent of PLU or a third party, or acts of others (including camp participants or non-participants). Every type of injury could occur. This may include broken bones, back or brain damage, death or dismemberment.

I hereby participate in the above activity scheduled at Pacific Lutheran University. I am fully aware of the special dangers and risks inherent in participating in the activity, including physical injury, death, or other consequences arising or resulting from the activity. I agree to accept full responsibility for such risks. I agree to accept responsibility for all implied risks and possible acts of negligence by other persons and/or agents of PLU. I further agree to advise activity planners of any physical or mental limitations I may have. I agree to be fully responsible for my own property and equipment related to this activity.

In consideration of my voluntary application and as a requirement to participate in this activity, I hereby release and indemnify Pacific Lutheran University and their staff of any and all liability, claim and cause of action arising out of or in any way connected with my participation in this activity offered at Pacific Lutheran University.

I also agree to allow any medical personnel the opportunity to treat a illness, injury, or any other medical condition. I agree to accept full responsibility for any medical costs which may result from my participation and for any treatment for any injury sustained while taking part in the program.

I have read this release and indemnification agreement and understand its meaning. This release is intended to bind by heirs, representatives, successors, assigns and administrators.

Signature of Participant*: ___________________________ Date:__/__/__________ Printed Name: ___________________________

Signature of Parent/Legal Guardian*: ___________________________ Date:__/__/__________ Printed Name: ___________________________
*Parent or legal guardian must also sign for participants under 18 years of age.

Being fully informed as to these risks, I hereby consent to the minor participating in the activity.

Address: ___________________________ City: ____________ State: ____________ Zip: ____________

Mailing Address (if different): ___________________________ City: ____________ State: ____________ Zip: ____________

Phones: ___________________________ Alternate Phones: ___________________________ email address: ___________________________
Medical Information (for PLU)

Participant Name: ____________________________ Social Security #: Not Needed
Program/Activity Name: ____________________________ Date(s): ____________________________

In case of Emergency, please notify:

(person 1 name) ____________________________ (person 2 name) ____________________________
(person 1 phone/alt phone) ____________________________ (person 2 phone/alt phone) ____________________________
(person 1 relationship) ____________________________ (person 2 relationship) ____________________________

Medical Information:

In the event a serious medical emergency occurs, care will be provided at a local medical facility. Please provide us with the following information as well as any additional information which would be appropriate for medical professionals to know in the event of an emergency.

Health Insurance Company: ____________________________ If unknown, leave blank
Policy Number: ____________________________ Group Plan: ____________________________
Current Medications: ____________________________
Known Allergies (drug, food, other): ____________________________
Known Conditions (asthma, other): ____________________________
Special Assistance Required
Or Any other Important Information: ____________________________

In the event of an emergency, I authorize the above program/activity staff and/or Pacific Lutheran University and/or Central Pierce Fire & Rescue to arrange for emergency transportation and/or emergency medical care.

(Signature of Participant)* ____________________________ (date) ____________________________ (Printed Name) ____________________________

(Signature of Parent/Legal Guardian) ____________________________ (date) ____________________________ (Printed Name) ____________________________

*Parent or legal guardian must also sign for participants under 18 years of age.