Student Intake Form - Observation Only

Student Name: ______________________________ Date: __________________________

Address: ____

Phone: ____

Email: ____

Date of Birth: ____

School and Program Attending: ____

Degree pursuing: ____

Department/Person you wish to be placed in/with: _________________________________

Role you wish to be placed with (MD, DO, PT, PA, NP, etc.):_______________________

Dates Available for Observation: ____

Preferred Geographic Locations: ____

Please submit the following information**:**

- ☐ Student Intake Form
- ☐ Student Observer Guidelines Form
- ☐ Student Confidentiality Statement
- ☐ Student Observer Health Form
- ☐ TB Test
- ☐ MMR Immunization
- ☐ Varicella Immunization
- ☐ Influenza Immunization
- ☐ COVID Vaccine Immunization

Student Observer

Prevea Health would like to take this opportunity to welcome you as a student observer. Providing clinic health care is a unique and demanding specialty. It is different from all other areas of health care and provides a challenging and rewarding experience.

Your role as a student observer will be educational and will enable you to experience the various aspects of health care. **Direct care and treatment is not possible as a student observer.**

GUIDELINES

- You are expected to be working directly with a Prevea Health staff member at all times.
- Permission for the observer experience must be granted from the school or employer prior to your first day.
- Confidentiality MUST be maintained at all times. By signing this form, you are acknowledging that you have been informed of the Prevea Health Compliance Program and the policies you must adhere to during your time spent here.
- You agree to maintain all information and experiences you see and/or hear as confidential and will not discuss or communicate the information with anyone in any form.
- You understand that should there be a violation of any Prevea Health policy, you need to report it to your supervisor immediately.
- Appropriate attire (business casual- no jeans, etc.) is expected at all times.
- All questions regarding your observer experience should be directed to the supervising clinic staff member.
- TB skin test must be completed within 1 year prior to your observation experience. Please provide a copy of results.
- Documentation/Verification of the COVID-19 vaccine. Acceptable verification: Wisconsin Immunization Registry record, facility record with signature/initials. Must be fully vaccinated, meaning 14 days after final dose.
- Documentation/Verification of the MMR vaccine. Acceptable verification: Wisconsin Immunization Registry record, facility record with signature/initials; or titer (blood test).
- Documentation of Varicella vaccine or immunity. Acceptable verification: Wisconsin Immunization Registry vaccine record; record with signature/initials of agent or agency that administered; or copy/date of titer (blood test). **Stated history of disease is not accepted.**
- Documentation of a current influenza vaccine for the flu season. (If flu shot is declined, must follow Prevea's masking directive)
- ****To access the Wisconsin Immunization Registry to obtain your records online, go to: http://www.dhs.wisconsin.gov/immunization/publicAccess.htm. Click on public access towards the bottom of the page and fill in your information to obtain what has been recorded. You will need your Social Security Number.*

The Prevea Clinic staff hopes you have a rewarding and educational experience.

I have read and understand the guidelines as described above.

________________________________ ________________
(Student Observer) (Date)

________________________________ ________________
(Clinic Staff Member) (Date)

____
(Department)

Confidentiality Statement

The patient's medical record plays a vital role in our effort to provide optimum medical care. It is a record of the patient's medical history for the use of the physician and must be kept strictly confidential. It is essential to the patient/physician relationship that all information exchanged is kept in strict confidence.

No patient information is to be released to anyone – relatives, friends, employers, insurance companies, and lawyers – **without the patient's written consent**.

If you read or discuss a patient's record without having a specific clinic related reason, or use any information contained in a patient's record for non-clinic business, **you will be immediately discharged from Prevea Health.**

______________________________ Signature

______________________________ Date

______________________________ Supervising Staff Signature

Student Observer Health Status

As Prevea Health strives to maintain a safe environment for all patients, visitors and employees, it is necessary to inquire about your current health status prior to starting your clinical observation experience.

My signature below verifies that I am currently in good health and free of any symptoms of communicable disease (cough, fever, etc.).

I understand that if on the day of my shadowing, I have any symptoms including, but not limited to, any upper respiratory symptoms, fever, sore throat, loss of taste and/or smell (regardless of COVID-19 vaccination status) or I have had close contact with someone with COVID-19 in the past 14 days, I will contact the provider and students@prevea.com to reschedule my shadowing experience.

Student name: ___________________________ **Student signature**: _________________________ **Date:** _______________
(please print)