Intermountain Healthcare

# Healthcare Careers 2018 Summer Camp Application

**(PLEASE PRINT CLEARLY)**

Name (First, Last) _____

Date of Birth_____ Gender _____ Male _____ Female

Phone (home) _____ (cell) _____

*Would you like to receive text reminders/updates? Yes_____ No_____

Email address_____

Address_____City_____State_____Zip_____

School_____Student # _____

Emergency Contact Name: _____

Phone: _____- _____-_____

Have you previously attended a Health Career summer camp? Yes_____ No_____ If so, where? _____

If selected, will you be 16 years old before summer camp begins? Yes_____ No_____

Our summer camp will be held:

- **Wednesday, June 13th 9:00 am to 2:30 pm – Intermountain Medical Center**
  Doty Education Center, Building 6, 5121 S Cottonwood Street, Murray UT

## Please review the following statement:

By signing below, I certify that all the information provided on this form is true and correct, to the best of my knowledge. If selected, I understand that my behavior must be professional at all times.

*Applicant signature*: _____*Date*:_____

**APPLICATION DEADLINE – Friday, June 1st**

*Please email the completed application and following forms to crstudentprograms@imail.org or fax to 801-442-2338. Please call 801-442-2243 or email crstudentprograms@imail.org if you have any questions.*

***Please note: Students will be notified by email, after the June 1st application deadline, on whether they have been accepted. For students who have been selected, additional details will be provided.***

Intermountain Healthcare

Revised: 11/2016

# High School Student - Intermountain Sponsored Event

**Check Applicable Event:** **Date of Event:** 6 / 13 / 18

- [x] Summer camp
- [ ] Career fair
- [ ] Specialty workshop
- [ ] "Medical Explorers"
- [ ] Other: _____

**Complete the following forms and return to your teacher or Intermountain Student Placement Coordinator**

A. Student Profile
B. Consent to Liability
C. Access and Confidentiality Agreement
D. Confidentiality Guideline
E. Immunization Requirements (if event is held at an Intermountain hospital or clinic)

## Student Profile / Identification

*Incomplete packets will be returned*

**Date:**_____ *(of packet completion and return)*

**Legal name:**_____ _____ _____
*First* *Middle Initial* *Last*

**Preferred first name** (if different from legal name):_____

**Date of birth:**_____/_____/_____ **Gender:** ☐ Male ☐ Female

**Last four digits of your Social Security number:**_____ *(for student identification)*

**Ethnicity:**

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Two or More Races ☐ Not Disclosed

**Currently employed by Intermountain Healthcare?** ☐ Yes ☐ No

If yes, what is your user name:_____

Employee number (if known):_____

**E-mail:**_____ **Phone:** _____-_____-_____

**Permanent address:** Street: _____

City: _____ State:_____ Zip:_____

**Emergency contact:** Name:_____

Phone: _____-_____-_____

**School:**_____ **Program/Class:**_____

**School instructor (teacher):**_____

**Hospital & department:** Intermountain Medical Center

**Completion of:**

☐ Required immunizations (see attached list)
☐ Flu immunization (seasonal). Date of current IM vaccine or FluMist (month/year): _____/_____
[x] Not required *if the event is independent of a hospital/clinic environment*

# Consent to Liability

*for students under 18 years of age or still in high school*

I, _____ (Parent), as legal guardian for _____ ("Child"), intending to be legally bound for myself and my heirs, assigns or personal representative, agree to the following in connection with the _____ ("school Program"), at _____ ("Facility"), a division of IHC Health Services Inc, ("Intermountain Healthcare" or "Intermountain"):

1. I consent to my Child attending and participating in the Program at the Facility.

2. I agree to indemnify and save harmless, Intermountain Healthcare their officers, agents and employees from and against any and all loss, damages, injury or death, damages to personal property, howsoever caused, resulting directly or indirectly from my Child's participation in the Program at the Facility.

3. I acknowledge Intermountain has not made any statement, representation or promise to me regarding any fact relied upon by me in entering into or executing this Consent to Liability and I specifically have not relied upon any statement, representation or promise of Hospital in entering into or executing this Consent to Liability.

4. I have carefully read this document and fully understand its contents and that it is a binding legal document.

5. My Child and I have carefully read and have discussed the attached Access and Confidentiality Agreement and we both fully understand its contents and understand it is a binding legal document.

6. I understand that my Child will not be permitted to participate in the Program if this Consent to Liability and the attached Access and Confidentiality Agreement, and HIPAA Agreement are not signed and returned to Child's advisor by _____, 20_____.

IN WITNESS WEREOF, I have executed this Consent to Liability this _____ day of _____, 20_____.

_____
Parent's Printed Name

_____
Parent's Signature

_____
Street Address

_____
City, State and Zip Code

_____
Phone Number

Intermountain
Healthcare

Intermountain℠ Healthcare

# Authorization to Use and Disclose Information for Media or Public Relations

Name: _____

Address: _____

_____

Date of Birth: _____

Phone number:
(_____)_____

Home: ☐ Cell: ☐

Work number:
(_____)_____

Email:
_____

This authorization allows Intermountain Healthcare to release this information:

- ☐ full name
- ☐ image (photographs, video, film)
- ☐ story and statements
- ☐ Other_____

I understand:

1. I can refuse to sign.
2. I can cancel this agreement, through writing the Student Programs department, at any time, for any reason, so my information cannot be disclosed in the future. Otherwise, this release will expire on _____ .
3. Refusing or changing my mind will not affect me, or my family, negatively in terms of treatment, payment, or patient benefits.
4. Federal privacy rules govern Intermountain's usage of this information, including allowing me to request, in writing, a copy of any information shared or used under this authorization.
5. I understand that others will see the information shared publicly because of this release. They may not be governed by the same Federal privacy rules.

I understand what information is being released and questions about this form have been answered to my satisfaction. I give authorization and release my information to Intermountain Healthcare to be disclosed in news media, public relations, publications, advertising, fundraising purposes, and other communications.

| | |
|---|---|
| Student Signature | Date |
| If Student is under 18,<br>Parent or Legal Guardian<br>Must Sign | Signature of<br>Witness (optional) |