

**CHILDREN'S HEALTHCARE OF ATLANTA
MAJORITY AGE PARTICIPANT OBSERVATION AGREEMENT**

This Agreement is made and entered into as of the ___ day of _____, 20____, by and between **CHILDREN'S HEALTHCARE OF ATLANTA, INC.**, a Georgia nonprofit corporation by and on behalf of itself and its corporate affiliates including, but not limited to **EGLESTON CHILDREN'S HOSPITAL AT EMORY UNIVERSITY, INC.**, a Georgia nonprofit corporation, d/b/a Children's Healthcare of Atlanta at Egleston, **SCOTTISH RITE CHILDREN'S MEDICAL CENTER, INC.**, a Georgia nonprofit corporation, d/b/a Children's Healthcare of Atlanta at Scottish Rite, and all other **Children's healthcare of Atlanta, Inc** affiliates as set forth in Exhibit A, attached hereto and incorporated by reference herein (hereinafter individually and collectively referred to as "Children's") and _____ (hereinafter referred to as "Participant"), concerning an arrangement for Participant's participation in an Observation Experience (hereinafter referred to as the "Experience") at Children's for the purpose of providing an opportunity for Participant to observe the clinical care and treatment of patients in the _____ Department/Unit.

GENERAL UNDERSTANDING

A. Children's will provide Participant the opportunity to participate in the Experience in accordance with the terms and conditions of this Agreement and applicable Children's policies. Participant understands and agrees that he/she will abide by all requirements, provisions, terms and conditions of this Agreement in consideration for the opportunity to participate in the Experience. Participant further understands and agrees that he/she will abide by Children's bylaws, rules and regulations as well as applicable Children's policies and procedures.

B. Children's and Participant agree that the Experience is made available with the consent of the _____ (hereinafter referred to as the "Department") at Children's Healthcare of Atlanta at _____ and will take place from _____, 20____, to _____, 20____. Children's Program Coordinator or designee (hereinafter referred to as the "Coordinator") will be responsible for oversight of the Participant while participating in the Experience.

C. Participant understands and agrees that this Agreement does not permit or provide for Participant's participation in direct patient care activities and Participant agrees that at no time and under no circumstances will he/she engage in any direct patient care activities.

D. Participant understands that his/her opportunity to participate in this Experience is at the sole discretion of Children's, and Children's may, in its sole discretion, immediately withdraw Participant at any time from participation in the Experience.

E. Participant understands and agrees that he/she will not be considered an employee of Children's for the purposes of compensation, workers' compensation insurance, or for any other purpose or benefit flowing from employment status. Participant will not hold himself/herself out as an employee or agent of Children's for any purpose. Participant shall, at all times while at Children's, wear appropriate clothing and an identification badge.

F. Participant agrees that, as part of his/her participation in the Experience, he/she will by necessity be exposed to and learn information considered confidential by Children's and confidential under federal, state and local law, including but not limited to patient medical information and other information considered personal and confidential by patients and their families. To protect such confidential information and the patients' and families' right to privacy, Participant agrees to keep confidential and not to use, discuss or disclose any information regarding any patient or patient's family. Participant agrees to comply with all laws, rules and regulations as well as Children's policies and procedures relating to patient privacy and patient rights to confidentiality. If Participant has any questions regarding confidentiality of patient and family information, Participant will consult with his/her Children's Coordinator. Participant understands and agrees that the restrictions on use and disclosure of confidential information, including information about patients and patients' family remain in effect during and at all times after Participant's participation in the Experience.

G. Participant understands and agrees that Children's retains overall supervisory responsibility for and authority over the care of patients and over all operational matters, and that Children's will maintain administrative and professional supervision of Participant at all times while Participant is present at Children's insofar as Participant's presence at Children's and participation in the Experience affect the operation of Children's

and its direct and indirect care of patients. If Participant has any questions or concerns regarding Children's policies and procedures or any other issues related to Participant's presence at Children's, Participant will consult with his/her Children's Coordinator.

H. Participant agrees to release Children's, its officers, directors, employees, agents and volunteers (the "Indemnities") from and against any and all liability and responsibility for any damage to Participant's property or injury to Participant's person (including illness and/or death) that might be caused by, or arise out of, or result from Participant's presence at Children's and participation in the Experience, regardless whether such damage or injury is caused by, arises out of or results from any act or omission of Indemnities. Further, Participant agrees to defend and hold Indemnities harmless against any and all claims, causes of action, liabilities, damages, costs and expenses (including reasonable attorney's fees) incurred by Indemnities as a result of any act or omission of Participant while Participant is at Children's or arising out of Participant's participation in the Experience.

I. Participant agrees that he/she meets Children's health screen requirements. If Participant's Experience is only for one day, Participant shall complete and submit the Observation Experience Participant Infection Checklist, attached hereto as Exhibit C-1 and incorporated by reference herein. If Participant's Experience is for more than one day, Participant shall complete and submit the Participant Health Screen Form, attached hereto as Exhibit C and incorporated by reference herein. Participant shall provide the applicable completed form on or before the first day of the Experience. In the event Participant is or becomes ill or experiences any signs or symptoms of illness, he/she shall immediately notify the Coordinator.

J. Participant shall provide his/her own personal health insurance, individually or through his/her parents. In the event Participant does not have personal health insurance, Participant understands and agrees that he/she shall be responsible for all costs incurred for any injury or illness Participant may suffer.

K. Notwithstanding anything in this Agreement to the contrary, the participant is aware of and shall fully comply with the Health Insurance Portability and Accountability Act of 1996("HIPAA") in its dealings with Children's under this Agreement. Participant shall:

1. Not use or further disclose protected health information (PHI) as that term is defined in the regulations implementing HIPAA, to any entity, organization or individual other than as permitted by this Agreement and shall not violate HIPAA.
2. Use appropriate safeguards to prevent unauthorized uses or disclosures of PHI and shall immediately report to Children's any unauthorized use or disclosure.
3. Require subcontractor or agent with the capability of access to PHI to agree in writing to these same safeguards and restrictions regarding the use of PHI.
4. Allow access to individual PHI by properly authorized patient representatives after providing written notice to Children's.
5. Make its methods of compliance with HIPAA available to the Secretary of Health and Human Services as required by law.
6. Return or destroy all PHI, at the sole discretion of Children's, upon termination of the Agreement.
7. Amend or correct PHI when required by law.
8. Not contest termination of the agreement if these provisions have been violated.

(SIGNATURES ON FOLLOWING PAGE)

Agreed to, as acknowledged by these signatures below:

PARTICIPANT:

Signature Date

Name (please print)

Address/Phone Number

CHILDREN'S HEALTHCARE OF ATLANTA, INC.
On behalf of itself and its corporate affiliates as set
Forth herein.

CHILDREN'S COORDINATOR:

Signature Date

Susannah Kidwell, M.S., CCC-SLP
Name (please print)
Rehab Director
Orthopaedics and Rehab Service
Line Title

Signature Date

Tricia Easley, B.S., O.T.R./L.
Name (please print)
Student Program Manager
Title

EXHIBIT A
Corporate Entities

Children's Healthcare of Atlanta Foundation, Inc.

Atlanta Children's Health Network, Inc.

Scottish Rite Pediatric Network, Inc. d/b/a The Children's Health Network

Emory-Egleston Children's Heart Center, Inc. d/b/a Sibley Heart Center Card

**EXHIBIT C
CHILDREN'S HEALTHCARE OF ATLANTA
PARTICIPANT HEALTH SCREEN REQUIREMENTS**

The following health screen requirements are to be met prior to participants beginning his/her educational experience at Children's.

1. TUBERCULOSIS – TB TEST MUST HAVE BEEN GIVEN WITHIN ONE (1) YEAR OF THE ENDING DATE OF THE EDUCATIONAL EXPERIENCE

- TB screening blood test: Positive _____ Negative _____ Date: _____ OR
 Tuberculin skin test: Positive _____ Negative _____ Date: _____

If positive have you:

1. Had a chest x-ray? Negative _____ Positive _____ Date: _____
2. Been treated with Anti-Tubercular Drugs? YES NO Date: _____

Two Step TB skin or blood test is required if no documentation of TB Test in the previous 12 months

- 1st Step Tuberculin skin test: Positive _____ Negative _____ Date: _____
 2nd Step Tuberculin skin test: Positive _____ Negative _____ Date: _____ OR
 TB Screening Blood Test: Positive _____ Negative _____ Date: _____

2. M.M.R. (MEASLES, MUMPS, RUBELLA) – if given instead of individual immunizations
Regardless of Date of Birth:

- Must have proof of two doses of MMR OR
 Evidence of immunity for Mumps, Rubella and Rubeola (Measles) by titer
MMR #1 Date: _____ MMR #2 Date: _____
Positive Rubella titer Date: _____ Positive Mumps titer Date: _____
Positive Measles/Rubeola titer Date: _____

3. VARICELLA (CHICKENPOX) – immunizations or proof of immunity by titer

- Must have proof of two doses of Varicella Vaccine or immunity by titer to Varicella
Varivax #1 Date: _____ Varivax #2 Date: _____
 Positive Varicella immune titer Date: _____

4. TETANUS, DIPHTHERIA, PERTUSSIS

- Proof of a 1-time dose of Tdap. Date: _____

5. HEPATITIS B VACCINE – Evidence of completed Hepatitis B series vaccines and immunity by titer for all direct patient care providers, and those with potential for exposure to blood and body fluids (OSHA category 1 & 2)

- Hepatitis B vaccine required? YES NO
Vaccine series Dates: #1. _____ #2. _____ #3. _____
 Positive Hepatitis B Surface antibody titer following the three series Date: _____

6. INFLUENZA VACCINATION – Participants are required to obtain the influenza vaccination prior to beginning his/her Educational Experience at Children's during Influenza Season. Flu season is determined by the state public health office of epidemiology and varies from year to year.

- Have had Annual Influenza Vaccination Date: _____

It is the responsibility of the Participant to immediately contact the Children's Coordinator and the Children's Employee Health Department if the Participant:

- a. is exposed to Varicella (Chickenpox) or Shingles with a negative history of Varicella;
b. is exposed to Measles, Mumps, or Rubella, if not immunized;
c. is exposed to Pertussis (Whooping Cough); and/or
d. acquires any of the above.

Note: Any participant having direct and or indirect contact with patients may not wear acrylic or artificial fingernails. Artificial and acrylic nails can carry hard to spot dirt and bacteria that can be dangerous to our patients. Please remove any potentially harmful fingernail polish or treatment before beginning your educational experience with Children's.

Please mail “Majority Age Agreement”
to:

*Children’s Healthcare of Atlanta
Attn: Janine Greenhill
Rehab Department - 2nd floor
1405 Clifton Road NE
Atlanta, GA 30322*