Tomah Health
TOGETHER IN CARE

STUDENT INFORMATION

Full Name:	**Today's Date:**
Mailing Address:	**Daytime Phone:**
	Date of Birth:
Current School/College:	**Year in School:**
Rotation Dates:	**Department/Specialty:**
Do you have any major medical problems that we should know about? Yes ☐ NO ☐	
If yes, please explain:	

Emergency Contact

Name:	**Relationship:**
Address:	**Cell phone:** **Work phone:**
Notes:	

Signature of Student _____ **Date** _____

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NON-EMPLOYEE ORIENTATION ACKNOWLEDGMENT

By signing below, I acknowledge that I have reviewed the following orientation video:

- Non-Employee Orientation Video

These documents include but are not limited to the below topics:

- Employee Health/Infection Control
- Quality/Compliance/CMS Fraud, Waste & Abuse
- Fire and Safety
- Sexual Harassment
- Personal Appearance
- Security
- Emergency Alerts
- HIPAA

_____ _____
Name (*please print*) Department

_____
Name of School/Company/Contract

Dates in the facility from_____ to _____

_____ _____
Signature Date

Please forward to Professional Development when complete

Tomah Health
Influenza Vaccination Healthcare Personnel Reporting Form

TH Staff Member, Volunteer, Student or Practitioner

Tomah Health (TH) is required by the Centers for Medicare and Medicaid Services (CMS) to report information regarding influenza vaccination in our facility. **All employees, practitioners, adult volunteers and students working in TH for at least one day during the reporting period, (October 1 through March 31), who were not vaccinated at TH must complete this form.** All information below must be completed on this form and returned to Employee Health. All students must have submitted the appropriate documentation prior to the start of their clinical rotation. This includes proof of vaccination or an exemption request with supporting document.

Name:_____ **Date of Birth:**_____

Please check your appropriate status:

_____ **Employee** ____ **Practitioner**

_____ **Volunteer** ☐ **Student** ____ **Other (please list)**_____

Please check all statements below that indicate accurate information for the above-named individual:

1. _____ I *received* an influenza vaccination
   from _____ (name of facility)
   on _____(date received).
   _____ **Proof of vaccination documentation for all employee types and volunteers must be forwarded to Employee Health no later than November 13th, 2025.**

2. _____ I am *declining* to receive an influenza vaccination for the current flu season based on (please indicate below by marking A or B):
   A. _____ Medical contraindication & have submitted physician letter
   B. _____ Religious contraindication & have submitted written explanation
   _____**I agree to wear a hospital-provided mask according to instructions for use at all times within the facility during the flu season.**

   _____ **Appropriate paperwork for all employee types and volunteers will be forwarded to Employee Health no later than November 13th, 2025**

3. _____ I acknowledge that I have reviewed the Vaccine Information Sheet for Influenza and understand the recommendations for the Influenza Vaccine.

I attest to the accuracy of the information given on this form by legibly printing and signing name below.

_____ _____ _____

Printed Name **Signed Name** **Date**

Influenza Vaccine (Injectable)
2025-2026 Influenza Vaccination Program * Vaccination Consent
Tomah Health (TH) Employee Health Services

Please complete all questions and information / data collection sections of this form*

The influenza vaccine is offered free of charge as a benefit to all employees, students, and volunteers.

PLEASE PRINT CLEARLY

Printed Name:_____ Date of Birth:_____ Dept._____

What is your association to TH?

_____ Employee _____ Student _____ Volunteer _____ Other Provider

Yes	No	(#2–3 Permanent Contra-Indications)
[ ]	[ ]	1. Are you allergic to eggs or egg products? (no longer a contra-indication, observe for 15 minutes)
[ ]	[ ]	2. Have you ever had Guillian-Barre Syndrome within 6 weeks of taking a flu shot?
[ ]	[ ]	3. Have you ever had an anaphylactic reaction to the influenza vaccine?
[ ]	[ ]	4. Did you receive a flu shot last year?
[ ]	[ ]	5. Do you have any signs or symptoms of illness?

- **If you have had recent chemotherapy, radiation therapy, or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, flu vaccination is still encouraged.**
- **Because of increased risk of influenza-related complications, the CDC and the ACIP recommended flu vaccination for women who will be pregnant or breast-feeding during the influenza season.**

Serious problems from influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so you can not get influenza from the vaccine. TH will provide Trivalent (three-component) influenza vaccines for the influenza season. The High-dose Seasonal Influenza Vaccine will be available for those over 65 years old as long as supplies are available.

Mild Problems: (If these problems occur, they usually begin soon after the shot and last 1-2 days)

- Soreness, redness, or swelling where the shot was given
- Fever
- Aches

Severe Problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is within a few minutes to a few hours after the shot.
- In 1976, a certain type of influenza (swine flu) vaccine was associated with Gullian-Barre Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

I received the current Vaccine Information Sheet (VIS) for the influenza vaccine. I had a chance to ask questions that were answered to my satisfaction. I understand the benefits & risks of vaccine & ask that the vaccine be given to me.

Signature:_____ Date:_____

For Office Use Only

Vaccine Manufacturer: [ ] GSK [ ] Sanofi Pasteur [] Other: _____ Lot #:_____

Site: [ ] Left deltoid [ ] Right deltoid Dose: 0.5 ml Expiration Date: _____

Signature:_____ (RN/LPN/PA/MA) Date:_____

Student Vaccine Attestation

By signing below, I attest that I will not come to clinical if I have a fever of (>100°F) or any of the following new unexplained symptoms: cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea.

If requested by Tomah Health, my represented school would be able to provide documentation of the following:

- Hepatitis B x3 or immune titer
- Measles, Mumps, & Rubella (MMR) x2 or immune titer
- Tetanus, Diptheria, and Pertussis (Tdap)
- Negative Tuberculosis Skin Test(s) or Blood Draw (Within the last 12 months)
- Varicella x2 or immune titer
- Influenza (October-April)
    - Must provide proof of this vaccine during these months. Please sign the Tomah Health Influenza Vaccination Healthcare Personnel Reporting Form. It is requested that all Influenza vaccinations for students, be administered by October 1st or prior to start of your clinical within the months of October and April.

Signature:_____

Date:_____

TOMAH HEALTH
CONFIDENTIALITY AND SECURITY AGREEMENT

(for Non-Employee Persons participating in care reviews, training exercises, and debriefings)

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Policies/Standards of Behavior available on HealthConnect (intranet), P&G Station and/or upon request. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

I WILL NOT:

- access, disclose, or discuss any Confidential Information with others, including friends or family
- Divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized
- Discuss Confidential Information where others can overhear the conversation
- Make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information
- Share/disclose user names, passwords, etc
- Use tools or techniques to break/exploit security measures
- Connect to unauthorized networks through the systems or devices

I AGREE:

- My obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company
- Upon termination, I will immediately return any documents, equipment, or media containing Confidential Information to the Company
- I have received training on how to protect health information/confidentiality as necessary and appropriate to perform my job responsibilities.
- I only receive confidential information on a need to know basis.

I UNDERSTAND:

- I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company
- I will act in the best interest of the Company and in accordance with its Standards of Behavior at all times during my relationship with the Company
- That violation of this Agreement may result or law enforcement involvement based on circumstances and evaluation.
- I understand and agree that the computer login and/or electronic signature is equivalent to a legal signature.
- I understand and agree to use hospital issued equipment for business purposes and no expectation of privacy.

Return to Health Information Services

_____ _____

Signature Date

_____ _____

Printed Name Date

_____

Agency Represented

AT A GLANCE – May I disclose protected health information for public health emergency preparedness purposes?

(From the perspective of the source of the information)