



STUDENT INFORMATION FORM

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:
School Contact for Emergencies (Name & Number)	Notes

Signature of Student _____ **Date** _____

Student Vaccine Attestation

By signing this document, I attest that I am up to date on the vaccines listed below. 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) within the last 10 years
- Negative Tuberculosis Skin Test(s) or Blood Draw (within the last 12 months)
 - TB skin tests: a two-step skin test within the last 12 months must be provided **OR** a one-step skin test within the last year and an additional TB skin test from the previous year.
- Varicella x2 or immune titer
- Influenza (October 1st -March 31st)
 - Must provide proof of this vaccine during these months (no later than the start of your first clinical rotation). Please attach to this document.
 - If refusing the Influenza vaccine for a medical or religious reason, please complete the Exemption Request Form, located at the bottom of the Tomah Health Influenza Student Form.
 - For religious exemptions, please provide a brief explanation for the exemption.
 - For medical exemptions, please provide proof of allergy or a written statement from your doctor.

Signature: _____

Date: _____

Tomah Health Influenza Information for Students

Influenza vaccination is required for all students who will be participating in a clinical or educational rotation at Tomah Health at any time between October 1, 2026 and March 31, 2027. Documentation of vaccination must be submitted prior to the start of the student's educational rotation. Any declination/exemption requests and their required supporting documentation (see below) must be submitted before the start of any student's rotation.

Students who wish to submit an exemption request for Influenza vaccination for religious or medical reasons, must complete the bottom of this form. All exemption requests will be reviewed by Tomah Health Administration. If exemption request is approved, the student must wear a surgical mask, according to the manufacturer's instructions at all times during their educational rotation.

Student Influenza Exemption Request

Name: _____ Date of Birth: _____

I am requesting an exemption for the Influenza vaccination for the current Influenza season based on (please indicate below):

_____ Medical Contraindications and have submitted a letter from my Primary Care Provider.

Medical contraindications must be confirmed by a formal letter from your provider on their office letterhead. This letter must include your physician's contact information and *detailed* information regarding the medical contraindication

_____ Religious Contraindication and have submitted a written explanation of beliefs.

By signing below, I am acknowledging that I am a student with the privilege of completing my clinical rotation at Tomah Health and will adhere to Tomah Health's policies and procedures. I agree to wear a hospital provided mask, according to the instructions for use at all times within the facility during my clinical/educational program rotation. 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 I provided and the written supporting documentation for my exemption by signing my name to this form.

Signature

Date



Check box if you are a student **AND** a Tomah Health employee.

07/2026

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 Professional Development (clinical rotation students) or HR (job shadows, contractors, other non-employed individuals)

Signature

Date

Printed Name

Date

Agency Represented



STUDENT 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 following 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.