



EHCO College Edition '24 **Summer Medical Seminar Application**

Hosted by: DRH Health EHCO Program

Location: DRH Health Campus

Date: June 17 - 21

Monday through Thursday – 8:30 a.m. to 11:00 a.m.

Friday – 8:30 a.m. until 12:30 p.m. – Final Day Lunch Provided

Eligibility Criteria:

- Recent high school graduate, current college student, or young adult ages 17-24
(Must have completed HS or have GED.)
- Must commit to be present to attend in person all five days of event
- Have an interest in possible future career in the medical field
- Be able to pass background check, completing pg 3 of OSBI form and copy of front of driver's license
- Must provide the following vaccine documentation:
 - Usual vaccines required for educational purposes: Measles, Hepatitis B, Mumps, Rubella, and Chicken Pox (Varicella)
 - Tuberculosis skin test/negative (PPD) (Available your physician's office, at Newberry Pharmacy, R & S #1, some of the Urgent Med places in Duncan)
- Submit completed application and \$50 fee

Questions: Please contact Lesa Hefner, Health Careers Advisor, DRH Health
580.251.8238 or lesa.hefner@drhhealth.org

Application Deadline: June 10, 2024 @ 5:00 pm. Space is limited. Apply early to ensure acceptance!

Student Name: _____ Age: _____
 Phone: _____ Email: _____
 Home Address: _____ T-Shirt Size _____

School Attending: _____ Current Grade Point Avg.: _____
 College current level: Freshman Sophomore Junior Senior

Please state why you are applying to attend this event:



Insurance and Emergency Information

Participant's Name: _____
Birth Date: _____ Phone: _____
Participant's Home Address: _____
Parent/Guardian Name: _____
Parent/Guardian Phone: _____ Email: _____
Insurance Company: _____
Name of Insured: _____
Policy #: _____ Group #: _____

Participant Medical Information

List medical information about the participant that would be helpful in case of emergency.

Allergic to medications? () Yes () No

If yes, what medications? List any allergies or other medical problems of the participant:

I consent to receive, or if participant is under 18, for my child to receive, emergency medical treatment in case of injury or illness. The information provided is accurate to the best of my knowledge.

Parent/Guardian Signature (required if participant under 18)

Date

Participant's Signature

Date



RELEASE FOR MEDICAL AND OBSERVATIONAL EXPERIENCES

(Participant Name-printed)

(Parent/Guardian Name-printed – required if participant is under 18)

I, the undersigned, hereby consent to participate or allow my child’s participation in a medical learning experience at DRH Health, as sponsored by the EHCO Program.

I understand and acknowledge that participation in activities taking place in a health care environment involves inherent risks and hazards, including the risk of exposure to disease and blood/body fluids, and other potential risks. Although I understand that these risks may have serious consequences, on behalf of myself or my child, I hereby expressly assume all of these risks, known or unknown, which could occur through my participation or my child’s participation in the Program, and, on behalf of myself or my child and, I assume personal responsibility for my health or my child’s health and safety while I or my child participates in the Program. In addition, I understand that I am responsible for expenses incurred for any medical or health care services (emergency or otherwise) I or my child may require as a result of participating in the Program.

As an inducement for and in consideration of my or my child’s participation in the Program, on behalf of myself or my child, I hereby agree that DRH Health, its subsidiaries and affiliated corporations and their respective directors, officers, employees and agents, will not be liable for any personal injuries, medical claims, damages or other expenses which may occur from my or my child’s participation in the Program. On behalf of myself or my child, I hereby release DRH Health, its subsidiaries and affiliated corporations and their respective directors, officers, employees and agents, from any and all claims or demands which I or my child may now have or have in the future which result from my or my child’s participation in the Program, and, on behalf of myself or my child, I agree not to sue DRH Health, its subsidiaries and affiliated corporations and their respective directors, officers, employees and agents, for any such claims or demands. This Release is intended to be as broad and inclusive as permitted by law, and if any portion of this document is found to be invalid, the rest of this document will remain in effect. This Release shall be binding on my heirs, executors, administrators and assigns.

I acknowledge that I have read this document in its entirety or that it has been read to me if I am or have been unable to read it.

Parent/Guardian Signature (required if participant under 18)

Date

Participant’s Signature

Date



**Student Tours
HIPAA Compliance/Confidentiality Statement**

By signing below, I agree to all terms and conditions of the following confidentiality agreement. While even though my site tour date may not yet have been determined, I authorize DRH Health to employ this signed agreement and its contents for the duration of my visit to their site.

DRH Health and its team members/volunteers must make every effort to prevent unauthorized disclosure of medical, personal, or other data about its patients and team members. We believe it is imperative that as a condition for touring, each student should be familiar with our confidentiality policy.

Confidentiality Policy:

Any information on a patient concerning their presence in the hospital, their reason for being there, the treatment they are receiving, or their past or current medical condition is confidential and may be released by authorized personnel only. Any knowledge, medical or personal, about a patient is not to be disclosed outside DRH Health. Such information should not be passed from one individual to another inside the hospital.

This policy was written to protect the right of the patient from unauthorized disclosure as well as to comply with both State and Federal law. As a routine matter, we must be very conscious as to our conversation outside the workplace.

To ensure that you understand the importance of practicing a strict code of confidentiality, we must request that you read and sign the statement below.

I fully understand the importance of following the confidentiality code and further understand that disclosure of any information regarding a patient and/or his/her condition may be a violation of Federal and State law and that unauthorized disclosure of confidential information may lead to repercussions.

Signature of Student

Date

Printed Name

Parent or Guardian Signature
(Required if student is under 18)

Parent or Guardian Printed Name



MEDIA CONSENT WAIVER

I do hereby authorize DRH HEALTH and the DRH HEALTH FOUNDATION to copyright, publish, and use (in all forms and media, and all manners for advertising trade, promotion, exhibition, or any other lawful purpose whatsoever) still, single, multiple or moving photographic or video portraits of me in which I may be included in whole or in part, or composite or distorted in character or form, in conjunction with my own or fictitious name, or reproductions thereof in color or otherwise for other derivative works made through any medium.

I do hereby waive any right I may have to inspect and/or approve the finished product or advertising copy that may be used in connection therewith, or the use to which it may be applied. I release DRH Health, the DRH Health Foundation and any other related representative from any liability whatsoever arising, or alleged to arise, by virtue of any form of aural, optical, compositional, or composite distortion that may occur while taking, processing, composing, editing, reproducing, publishing, or displaying said media. I further grant DRH Health and the DRH Health Foundation with the sole rights to any performance contained in said media.

I am the person named below and have legal authority to execute the above release. I approve the foregoing and waive any rights in the premises.

Name: _____ Age: _____

Signature: _____ Date: _____

Email: _____

Parent Signature (required if student under 18):

Communications/Marketing Department Use

Shot Locale: _____

Notes: