

	<b>Lower Providence Emergency Medical Service Standard Operating Guidelines</b>	
	<b>Subject:</b> <i>Infection Control</i> – Student & Ride Along Liability Waiver	<b>SOG #300-001C</b>
	<b>Approved:</b> Chief Christopher J. Reynolds	<b>Initiated:</b> January 2022  <b>Revised:</b> N/A

## ***Student and Ride-A-Long / Observer Liability Waiver***

*If under 18 parent/ guardian must sign.*

I \_\_\_\_\_ am aware that I may be exposed to an infectious disease(s) and/or potential injuries, while participating as a student or observer with Lower Providence Emergency Medical Services.

I understand that the diseases that are listed below, I may be exposed to, but are not limited to:

Tuberculosis  
 Hepatitis A, B, C, D, E, or F Viruses  
 Human Immunodeficiency Virus (HIV)  
 Conjunctivitis  
 Herpes  
 Streptococcal Viruses  
 Viral & Bacterial Respiratory Infections  
 Syphilis  
 Aseptic Meningitis

**Initial:** \_\_\_\_\_

I understand that Lower Providence Emergency Medical Service is not liable for **any** medical expenses that I may incur because of participation as a student or observer with Lower Providence Emergency Medical Service. (Including injuries and exposures.)

**Initial:** \_\_\_\_\_

I understand that if I am participating in Lower Providence Emergency Medical Service activities and I am exposed to an infectious disease(s). I am obligated by law to report the incident to the Lower Providence Emergency Medical Service Designated Infection Control Officer as stipulated in the OSHA Stand 1910.1030.

**Initial:** \_\_\_\_\_

I attest that I have been educated on the risks of participating in Lower Providence Emergency Medical Service, activities by a Lower Providence Emergency Medical Service Officer or Designee.

**Initial:** \_\_\_\_\_

I attest that I have been educated on the non-disclosure of patient information in accordance with The HIPPA Omnibus rule by a Lower Providence Emergency Medical Service Officer or Designee.

**Initial:** \_\_\_\_\_

*Student and Observer Liability Waiver*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date (s) of Participation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Participants Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Officer or Designee: \_\_\_\_\_ Date: \_\_\_\_\_

