



McALLEN

INDEPENDENT SCHOOL DISTRICT

Career and Technology Health Science Technology Program EKG/ECG Clinical Student Agreement Form

I understand that during the course of my program of study, I will have the opportunity to practice performing electrocardiograms on consenting adults/volunteers.

I understand that these are not invasive and minimal risks are involved and I will be required to maintain privacy.

I understand that I must follow Universal Precautions as outlined by Centers for Disease Control (CDC) and Occupational Safety and Health Administration (OSHA) when necessary.

I understand that I must comply with HIPAA (Health Information Portability and Accountability Act of 1996) and that I must maintain confidentiality.

I understand that a clinical faculty member/Teacher must be in attendance during any practice session in which venipuncture or skin puncture are practiced.

I will not perform any electrocardiograms in a practice session unless a clinical faculty member/Teacher is present.

I will comply with the guidelines set forth by my School District during my clinical sessions.

Student: _____ Date: _____

Parent: _____ Date: _____

Teacher: _____ Date: _____