Nicklaus Children's Hospital | Dr. Moises Simpser VACC CAMP

***** COMPANION APPLICATION *****

Dear VACC Camp Applicant:

You have expressed a need to have your home care nurse or respiratory therapist attend VACC Camp with your family. To introduce this person to us, please complete and return the Companion Application as well as proceed with the requirements with the State of Florida to accompany the camper to Miami (form enclosed).

Email the completed application to bela.florentin@nicklaushealth.org. The notification letter for the Florida Board of Nursing should be sent to the address on their form, please email us a copy too.

Don't hesitate to call if we might be of further assistance in this matter.

Cordially,

Bela Florentin
VACC Camp Coordinator

Nicklaus Children's Hospital | Dr. Moises Simpser VACC CAMP

*** COMPANION APPLICATION ***

If our family is invited to VACC Camp, in order to attend we would need to have our ☐ home care nurse ☐ respiratory therapist come to camp with us.

This is necessary because _____

_____.

The nurse/therapist who would attend camp with us is:

Name: _____

Agency: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

ATTACH A COPY OF THE NURSE/THERAPIST'S CURRENT LICENSE

_____
Nurse/Therapist's Signature

_____
Parent/Guardian's Signature

_____ Date: _____
PRINT Parent/Guardian's Name

RETURN TO:
Dr. Moises Simpser VACC Camp
Nicklaus Children's Hospital
3200 SW 62nd Ave
Suite 203
Miami, Florida 33155-4076

Phone:
(305)662-VACC or 662-8380

EXCEPTION TO NURSE PRACTICE ACT AND NOTIFICATION REQUIREMENTS TO ACCOMPANY AND CARE FOR A PATIENT TEMPORARILY RESIDING IN FLORIDA

The Florida Legislature granted an exception to Chapter 464, Florida Statutes, the Florida Nurse Practice Act for a legally qualified nurse of another state whose employment requires the nurse to accompany and care for a patient temporarily residing in Florida. Florida Statutes, Section 464.022(12), reads as follows:

> *"The practice of nursing by an legally qualified nurse of another state whose employment requires the nurse to accompany and care for a patient temporarily residing in this state for not more than 30 consecutive days, provided the patient is not in an inpatient setting, the board is notified prior to arrival of the patient and nurse, the nurse has the standing physician orders and current medical status of the patient available, and prearrangements with the appropriate licensed health care providers in this state have been made in case the patient needs placement in an inpatient setting."*

The nurse must provide notification to the Division of Medical Quality Assurance, Board of Nursing prior to arrival in Florida. The notification must include the nurse's name (as it appears on the license), jurisdiction in which licensed is held, and license number and the address of the nurse. Also, the notification must include an affirmation that the nurse has the standing physician orders and current medical status of the patient and that prearrangements with the appropriate licensed health care providers in Florida have been made in case the patient needs placement in an inpatient setting. We encourage you to use the enclosed letter of notification.
Notification letters should be sent to:

Florida Board of Nursing
4052 Bald Cypress Way
BIN CO2
Tallahassee, Florida 32399-3252
or FAX: (850) 617-6460

If you have any questions or need additional information, you may email us at:
MQA_Nursing@doh.state.fl.us.

Date: _____

To: **Division of Medical Quality Assurance**
Florida Board of Nursing
4052 Bald Cypress Way, Bin #CO2
Tallahassee, FL 32399-3252

This is to notify you that I, _____
(Please type or print First, Middle and Last Name)

licensed as _____ in the State of _____ , License Number _____
(LPN, RN, ARNP)

will be accompanying and caring for _____
(Please type or print patient's First, Middle and Last Name)

in the State of Florida from _____ through _____.
(MM/DD/YYYY) (MM/DD/YYYY)

I am aware of and in compliance with ALL of the below listed requirements of the Florida Nurse Practice Act. **(Please initial each requirement).**

- ☐ Patient is not in an inpatient setting.
- ☐ Visit is for no more than 30 consecutive days.
- ☐ I am in possession of the patient's standing physician orders and current medical status.
- ☐ I have made pre-arrangements with the appropriate health care providers in Florida should the patient require placement in an inpatient setting. I am aware of the location of the appropriate health care provider/facility in the area being visited by the patient under my care.

_____ Signature

_____ Email Address

_____ Street Address

_____ Agency Name (if applicable)

_____ City, State and Zip Code

_____ Agency Telephone Number (if applicable)

_____ Daytime Telephone Number

_____ Agency Fax Number (if applicable)

General Waiver of Liability

Please fill one out for EACH person attending the Camp.

In consideration of Shake-A-Leg Miami, Inc. ("SALM") extending to me the opportunity to perform services for, utilize services of, participating in programs provided by SALM, I fully assume all risks that might arise, both known or unknown, and both inherent to the program or activity in which I am engaging and any risks that are not inherent, and waive all liability for all such risks, including without limitation any potential liability that SALM may have for its own negligence or the negligence of any of its agents, officers, directors, or employees, in connection with my participation in the program or activity, and in particular, without limitation, to the extent permitted by law, I and my heirs, representatives, executors, or administrators and my undersigned parent, guardian or aide (if applicable) remise, release, indemnify, acquit and hold harmless and forever discharge SALM and its directors, officers, employees, agents, instructors, volunteers, rescue and support personnel, from any and all claims and liability, including without limitation liability for SALM's and its directors', officers', employees', agents', instructors', volunteers', rescue and support personnel own negligence, and all obligations, damages, claims, causes of action, judgements, costs and charges which I may suffer or which may be incurred by me for any reason of any occurrence during my travel to and from the activity or program, and during my participation therein, whether resulting from any acts, omissions or negligence or from acts of God or nature. I also agree to assume liability for all and any damages to SALM property that is under my control while participating in any SALM activity.

During my participation, I hereby agree to comply with all SALM rules and regulations, applicable county and municipal ordinances, and with the laws of the State of Florida and the United States. I further hereby give my full and unconditional permission to SALM for the free use of my name, likeness, and image (including without limitation permission to use any photo and video in which I may appear) in any present or future media story, promotion, advertisement, or account of an SALM related program, event, or activity, including without limitation in connection with any present or future public relations or fundraising event or activity.

☐ **CHOICE OF LAW:** I understand and agree that the law of the State of Florida will apply to this contract.

☐ **I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE.**

Adult Staff / Participants

Printed name: _____ Signature: _____

Youth Staff / Participants

I am the parent or legal guardian of the minor named below. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release.

Minor's name: _____ Parent's name: _____

Relationship to minor: _____ Signature: _____

Shake-A-Leg Miami SINCE 1990

Date: _____