NORTH CEDAR ACADEMY

Student and Parent Information

Complete ALL fields. Mark 'N/A' where appropriate.

STUDENT INFORMATION

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Email address	Cellphone

WeChat	WhatsApp	Languages Spoken at Home

PARENT / GUARDIAN INFORMATION (1)

First (Given) Name	Middle Name	Last (Family) Name	Date of Birth (MM/DD/YYYY)

Relationship to Student	Email address	Emergency Phone Number

Cellphone	WeChat	WhatsApp

Languages Spoken at Home:	Interpreter Needed (circle one): YES NO

PARENT / GUARDIAN INFORMATION (2)

First (Given) Name	Middle Name	Last (Family) Name	Date of Birth (MM/DD/YYYY)

Relationship to Student	Email address	Emergency Phone Number

Cellphone	WeChat	WhatsApp

Languages Spoken at Home:	Interpreter Needed (circle one): YES NO

NORTH CEDAR ACADEMY

Student Medical Information

If you are a returning student updating your medical information, please only mark changes that have occurred since your last day of attendance. If you require additional room for explanation, please use the back of this form.

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Primary Contact	Relationship

Primary Contact Preferred Communication (phone number, email address)

Allergies (foods, medication, insects, contacts, etc) **& Symptoms of Reactions**

Physical Restrictions

History	Yes	No	History	Yes	No
Heart Condition	❑	❑	Dental Braces	❑	❑
Diabetes	❑	❑	Depression	❑	❑
Asthma	❑	❑	Anxiety	❑	❑
Epilepsy	❑	❑	Sleep Disorder	❑	❑

Other Conditions (please describe in detail)

Are you currently taking any medications? ❑ Yes ❑ No

Tel: 1.715.532.0201
Fax: 1.715.532.9916

1500 Port Arthur Rd
Ladysmith, WI 54848 USA

NORTH CEDAR ACADEMY

Authorization for Administration of NON-PRESCRIPTION Medication

This form is for non-prescription medication that your child will be bringing with them to campus. All medications must be administered to students by trained North Cedar Academy staff.

One (1) form PER MEDICATION is required.

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Primary Contact	Relationship

Parent's Statement

1. Reason for medication:
2. Name & type of medication:
3. Dosage/amount to be administered:
4. Frequency/times of dosage:
5. Duration (week, month, indefinite, etc.)

Parent/Guardian Request and Approval

I hereby request and give my permission for the designated staff of North Cedar Academy (NCA) to administer the non-presciption medication on this form to my child. I further exonerate the designated staff of NCA from any liability resulting therefrom. I shall inform NCA of any changes in my child's health or medication(s). **It is the policy of NCA that medication be brought to school in the original container. Any medicine not in the original container will not be dispensed.** ***All international medication must be identified in english and with the appropriate dosage.*** The Authorization for Administration of Non-Prescription Medication is valid until the student withdraws, transfers, or graduates from NCA.

Parent's Signature: _____ **Date:** _____

Tel: 1.715.532.0201
Fax: 1.715.532.9916

1500 Port Arthur Rd
Ladysmith, WI 54848 USA

NORTH CEDAR ACADEMY

Standing Orders for Medication Administration

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Primary Contact	Relationship

These medications will be administered by NCA staff to students for the listed symptoms. If there is a medication that you do NOT want your child to receive, please mark the box (☒) next to the name of the medication. Medications that cause allergic reactions should also be listed on the Student Medical Information form. This form is valid until the student withdraws, transfers, or graduates from NCA.

Allergies: ❑ Loratadine (Claritin) - 10 mg 1 tablet daily for sneezing and runny nose
❑ Benadryl - 25mg 1-2 capsules every 6-8 hours as necessary for sneezing and runny nose

Cold & Congestion: ❑ Pseudoephedrine - 30mg 1 tablet every 4-6 hours PRN for nasal congestion

Car Sickness: ❑ Dramamine - 1 tablet every 8 hours (should be administered prior to a long bus/car ride)

Constipation: ❑ Miralax - 1 cap full in 8 ounces of clear liquids daily

Cough: ❑ Robitussin - (generic dextromethorphan) 2 tsp (10cc) every 4-6 hours as needed for cough
❑ Cough drop - 1 every 2-3 hours

Cuts/Abrasions/Scrapes/Burns: ❑ Triple Antibiotic Ointment - 2-3 times per day as needed; cover with band--aid and assess for infection

Diarrhea: ❑ Imodium - 2 tablets following the 1st loose stool; 1 tablet every 8 hours as needed for diarrhea

Digestion/Gas/Stomach Discomfort: ❑ Tums - 2 chewable tables every 4 hours as needed for upset stomach and heartburn

Eye Irritation: ❑ Artificial Tears - 2-3 drops to each eye as needed

Fever: ❑ Tylenol Extra Strength - 2 tablets every 4 hours for fever

Headaches: ❑ Ibuprofen - 200mg 2-3 tablets every 4-6 hours (will not be administered if stomach is empty) or
❑ Tylenol - 500mg 1-2 tablets every 4-6 hours

Menstrual Cramps: ❑ Ibuprofen - 200mg 2-3 tablets every 4-6 hours as necessary
(will not be administered if stomach is empty)

Pain/Aches/General Discomfort: ❑ Acetaminophen (Tylenol) - 500mg 1-2 tablets every 4-6 hours

Rash/Itching: ❑ 1% Hydrocortisone Cream - Topically 3-4 times daily

Parent's Signature: _____ **Date:** _____

Tel: 1.715.532.0201
Fax: 1.715.532.9916

1500 Port Arthur Rd
Ladysmith, WI 54848 USA

NORTH CEDAR ACADEMY

Authorization for Administration of PRESCRIPTION Medication

This form is for prescription medication that your child will be bringing with them to campus. All medications must be administered to students by trained North Cedar Academy staff.
One (1) form PER MEDICATION is required.

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Primary Contact	Relationship

PART I - Physician's Statement

1. Reason for medication:
2. Name & type of medication:
3. Dosage/amount to be administered:
4. Frequency/times of dosage:
5. Duration (week, month, indefinite, etc.)
6. Possible side effects/symptoms of medication:
7. Contact me should the following occur:

Physician's signature:	Date:
Physician's address:	Phone number:

PART II - Parent/Guardian Request and Approval

I hereby request and give my permission for the designated staff of North Cedar Academy (NCA) to administer the medication prescribed on this form to my child, and I authorize them to contact the child's physician if necessary. I further exonerate the designated staff of NCA from any liability resulting therefrom. I shall inform NCA of any changes in my child's health or medication(s). **It is the policy of NCA that medication be brought to school in the original container. Any medicine not in the original container will not be dispensed.** *All international medication must be identified in english and with the appropriate dosage.*

Parent's Signature: _____ **Date:** _____

Tel: 1.715.532.0201
Fax: 1.715.532.9916

1500 Port Arthur Rd
Ladysmith, WI 54848 USA

Patient name			
MHN	DOB	Age	Gender

Release of Information Authorization

A Patient

Previous last name (if any) | Daytime phone number

Address

City | State | ZIP

B Who has the information that is to be released

☑ Marshfield Clinic Health System, Inc./Family Health Center, 1000 N. Oak Ave., Marshfield, WI Phone: 1-800-782-8581, ext. 7-5687

☐ _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

C To whom the information should be released

Name: North Cedar Academy | Phone number: 715 532 0201 | 928 202 1096

Attention: Student Services, School Nurse, Administration | Fax: 715 532 9916

Address: 1500 Port Arthur Road

City: Ladysmith | State: Wisconsin | ZIP: 54848

D Medical records or other records to be disclosed

Check (✓) box(es) of the records to be released per this request (if minor is signing this authorization, see section titled "Special medical record release by minor")

Medical records:

☑ Consults	☑ Correspondence	☑ X-ray reports (See Section E)	
☑ Medical history and notes	☑ Dental	☑ Surgical reports	☑ HIV/AIDS test results
☑ Laboratory/Pathology reports	☑ Prescriptions	☑ Hospital records	☑ Forms/Opinion reports
☑ Billing/Financial records	☑ Immunizations	☐ School records	☐ Third-party records

☐ By specific doctor, for a specific diagnosis or a specific date range _____

☑ Other, specify 2 way written and verbal communication

Mental health/alcohol & other drug abuse/neuropsychology records:

Specify facility: ☑ Marshfield Clinic Health System ☐ Family Health Center

☑ Mental health AND/OR ☑ Alcohol & other drug abuse AND/OR ☑ Neuropsychology

☐ By specific doctor, for a specific diagnosis or a specific date range _____

☐ Other, specify _____

E Radiology films, pathology slides, or photographs to be disclosed

Check (✓) boxes below for the films, slides or photographs to be released per this request:

☐ Original x-ray of _____ ☐ Mailed date (m/d/y) ____ /____ /____

☐ Photographs (return loaned films/slides within 30 days)

(define type _____) ☐ Pick up date (m/d/y) ____ /____ /____

☐ Pathology slides of _____ By _____

F Method of release

☐ Email (use of encryption required) Email address _____

☑ Paper ☑ Other, specify +1 715 532 9916

Note: Information supplied electronically is in PDF format and is encrypted.

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

G

Special medical record release by minor

I am a minor and I have received medical care that requires or allows me to consent to the release of medical records of this care to my parents or any one else.

Check (✓) boxes of medical records to be disclosed:

- ☐ Outpatient alcohol or other drug dependency care (12 years or older) *(parent may also be required to sign below)*
- ☐ Inpatient alcohol or other drug dependency care – detoxification only (12 years or older) *(parent may also be required to sign below)*
- ☐ Rape or sexual assault/abuse (12 years or older) *(parent may also be required to sign below)*
- ☐ Outpatient mental health care (14 years or older)
- ☐ Inpatient mental health care (14 years or older)
- ☐ Neuropsychology notes (14 years or older) *(parent may also be required to sign below)*
- ☐ HIV/AIDS test results (14 years or older)
- ☐ Sexually transmitted disease (17 years or younger)
- ☐ Pregnancy test (17 years or younger) *(parent may also be required to sign below)*
- ☐ Birth control pills or devices (17 years or younger) *(parent may also be required to sign below)*
- ☐ Pregnancy-related care or care of newborn (17 years or younger)
- ☐ Physician at Marshfield Clinic Health System (e.g. my spouse, parent, child) can access my electronic medical record (EMR) including but not limited to information above *(parent may also be required to sign below)*

Patient signature _____ Date (m/d/y) ____ /____ /____

H

Reason for the release

Check (✓) box below to indicate the reason for the release per this request:

- ☑ Continuing health care needs
- ☐ Disability
- ☐ Transfer of care
- ☑ Care coordination or case management
- ☐ Second opinion/referral
- ☐ Personal
- ☐ Financial assistance
- ☐ Preemployment or medical evaluation
- ☑ Billing, collection or payment of claims
- ☐ Post-employment testing or medical
- ☐ Employment determination (non-work-related illness or injury)
- ☐ Litigations
- ☑ Other, specify sharing of health information

I

Expiration
Check (✓) box to indicate the expiration per this request

This authorization will remain in effect:

- ☐ From the date this authorization is signed until the _____ day of _____ , 20 _____
- ☐ Until you cancel this authorization in writing.
- ☑ Until the following event occurs, specify event patient withdraws, transfers or graduates from North Cedar Academy
- ☐ Other, specify _____

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

J

By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form, including the notices below.

Patient signature (Patient's legal representative) _____ (Relationship to patient) _____ Signature date (m/d/y) ___/___/___ Phone number _____

If authorizing release of Marshfield Clinic Health System medical records to an outside organization/person, send completed authorization to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

For any other authorizations, including but not limited to disability/FMLA forms to be sent to insurance companies, employers, etc., send completed authorization to: Health Information Management, HM2, Marshfield Clinic Health System, 1000 North Oak Avenue, Marshfield, WI 54449 Fax: 715-221-5847 E-mail: disability@marshfieldclinic.org

Note: This authorization will be returned and records will be delayed if all required sections are not completed.

Redisclosure notice to patient: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, or health plans, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of patient health care records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization

- *Right to receive copy of this authorization* – You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* – You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding:
  - research-related treatment
  - health plan enrollment or eligibility
  - the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party
- *Right to withdraw this authorization* – You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Health Information Management (medical records) department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* – You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information Management (medical records) department.
- *HIV test results* – Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- *Mental health treatment records* – You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

Patient name			
MHN	DOB	Age	Gender

Treatment of Minors in Parent/Legal Guardian Absence

Consent

To comply with Wisconsin law, Marshfield Clinic Health System requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to the care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

☑ I/We *(parent's/legal guardian's name)* _____ authorize:

Appointee *(person authorized to consent)* North Cedar Academy Staff

Relationship to patient in loco parentis Appointee's phone number 715 532 0201 | 928 202 1096

Appointee's address 1500 Port Arthur Road, Ladysmith, Wisconsin, 54848

to consent to – check (✓) all that apply:

☐ Emergent or urgent care (including mental health treatment) at Marshfield Clinic Health System and affiliates when I cannot be reached

☐ Medical treatment, mental health treatment or dental care – including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia (except for a local anesthetic) – at Marshfield Clinic Health System and affiliates

☑ Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic Health System

for my child *(patient's name)* _____

during the period *(not to exceed maximum of 1 year)*:

☐ Date *(month/day/year)* _____ /_____ /_____ to _____ /_____ /_____

☑ For a maximum period of 1 year

☐ I/We *(parent's/legal guardian's name)* _____ authorize my driving-age child *(patient's name)* _____ to receive routine care, unaccompanied during the period *(date – month/day/year)* _____ /_____ /_____ to _____ /_____ /_____

☐ I/We *(parent's/legal guardian's name)* _____ authorize my child *(patient's name)* _____ to attend physical/occupational therapy appointments unaccompanied during the period *(date – month/day/year)* _____ /_____ /_____ to _____ /_____ /_____

☐ Providers at Marshfield Clinic Health System and affiliates should try to contact me before providing care using the following numbers:

Home phone _____ Work phone _____ Cell phone _____

I further agree to reimburse Marshfield Clinic Health System health care provider for the cost of rendering these services to the extent that the minor's insurance does not pay for these services.

Child's parent/legal guardian signature _____ Relationship to patient _____

Child's parent/legal guardian address _____ Parent/Legal guardian phone number _____ Signature date (m/d/y) ____/____/____

Send completed form to: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consents@marshfieldclinic.org

Hospital Sisters HEALTH SYSTEM

Patient Label

AUTHORIZATION TO COMMUNICATE HEALTH AND BILLING INFORMATION TO DESIGNATED PERSONS

As the patient, I understand that I am the primary person to receive information from physicians and other caregivers regarding my health condition, treatment and progress. However, other individuals may desire or have a need to receive information about my condition and health care services. I authorize the staff & physicians at Hospital Sisters Health System on its own behalf and on behalf of all its affiliate hospitals and entities and Prevea Health (identified as "HSHS") to provide verbal information about my **TREATMENT** (health, plan of care, treatment, appointments, and my condition) and **BILLING** (information about my account in order to assist me with my insurance and payments) to the persons named below for the purpose of keeping them informed of my progress or assisting with my care. (Please note, we reserve the right to utilize clinical judgment in determining with whom we need to communicate based upon your health care needs, i.e. emergency situation.)

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

I hereby authorize HSHS to verbally disclose protected health information to the following: (I agree that this authorization includes the release or disclosure of alcohol/drug abuse, HIV test results, and Mental Health/Developmental Disabilities unless I check the applicable box below)

Name	Relationship	Telephone Number
NCA Administration, Student Services, School Nurse 1500 Port Arthur Rd, Ladysmith, WI 54848	in loco parentis	715 532 0201 | 928 202 1096

☐ I decline HSHS verbally sharing my treatment information with others, excluding emergency situations as indicated above.

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

☒ **Voice Mail**: Except for appointment reminders and billing inquiries, I understand that I will not be left voicemail messages regarding my health unless I agree to the following. I understand that messages left on voice mail may be subject to access by others and therefore are not a secure way to communicate confidential information. I understand that because of this risk HSHS advises that protected health information should not be left on voice mail. **By checking this box, I agree that HSHS may communicate my health information noted above to me via my voice mail at the number listed above** and I release HSHS and its employees, officers, and directors from all liability for any unintended disclosure or consequence as a result of communicating my protected health information to me in this manner.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer be protected by Federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Information Disclosed - I understand that I have a right to know what information was disclosed to the above individuals. **Right to Receive a Copy of This Authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form. Treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this authorization. **Right to Revoke This Authorization** – I understand that I may revoke this authorization. A description of how to revoke the authorization and any exceptions are included in the Notice of Privacy Practices. This notice is available through our facility website or at the patient registration desk. **HIV Test Results:** HIV test results are protected under Wisconsin state statute 252.15 and the Illinois AIDS Confidentiality Act (410 ILCS 305 et seq) may not be disclosed without written informed consent/authorization, except to persons or organizations that have been given access by state law. A list of those persons/organizations is available upon request.

EXPIRATION: I understand that this authorization will remain in effect until patient withdraws or graduates from NCA **or** I choose to revoke it.
(Indicate event or date)

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name

If signed by a person other than the patient, complete the following:
1) Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2) Legal authority: ☐ parent* ☐ legal guardian ☐ activated POA for Health Care ☐ next of kin/executor of deceased
*By signing above, I hereby declare that I have not been denied physical placement of this child.

Original: Chart Copy: Patient

PREVEA health

Request for Medical Care

Patient Name _____
(Last) (First) (Middle) (Date of Birth)

I. Medical Care Request and Authorization

I understand that I may have a condition that requires medical care. I am requesting and authorizing medical care by Prevea Health, any of the physicians associated with Prevea Health and other health professionals who are associated either with Prevea Health or the facility at which the medical care is rendered.

I am aware that medicine is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of my medical care. I understand that unforeseen conditions may arise during the rendering of my medical care and I hereby authorize Prevea Health and its designees to perform any other procedures they deem appropriate in the exercise of their professional judgment to address such conditions if I am otherwise unable to consent.

I recognize that I may, at any time, be a participant in and make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment, the right to formulate advanced directives and to provide any such directive for my physicians and health care providers to be aware of and to rely on.

I understand that students under appropriate supervision may observe or participate in my care; however, I have the right to refuse such observation or participation at any time.

II. CONSENT TO TELEPHONE CALLS (including WIRELESS), EMAILS, TEXTS:

If at any time I provide a telephone number through which I may be contacted, I consent to receive calls (including autodialed calls and pre-recorded messages), emails and text messages at that number from Prevea Health, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, regarding the services rendered, or my related financial obligations. I understand I may receive calls, email and text message communication regarding services or activities conducted on behalf of Prevea Health.

III. Financial Agreement

I understand that I am financially responsible for charges incurred for medical care rendered by Prevea Health. I understand that government payers and insurance companies may have restrictions on reimbursement for medical care rendered by Prevea health. These restrictions may include pre-certification, use of designated facilities, frequency of tests performed, non-covered services, deductibles, co-payments and other requirements. I understand that it is my responsibility to comply with such restrictions and that I will be personally responsible for any charges not reimbursed by other payers, to the extent allowed by applicable law.

If you are here for an office visit, please be aware that we will bill you for your office visit. Additionally, we may also bill you for: (i) additional services ordered by your provider in connection with your visit, including, but not limited to, laboratory tests and radiology services; and (ii) additional procedures performed by your physician during your office visit. Please be advised that additional services and procedures may be subject to your insurance plan's benefits, as well as deductibles, coinsurance and copayments required under your plan.

If you have any concerns regarding potential charges, please contact your insurance company with specific questions about what may or may not be covered. We will be happy to assist you by providing any medical information your insurance may need to determine your coverage.

We would be happy to answer any questions you may have about prices associated with your care. You may contact Prevea Health's Price Estimation Line at (920) 496-4700 for assistance.

I hereby authorize my insurance company or their payer to make payment directly to Prevea Health for services provided to me or to anyone else covered by my insurance for whom I am responsible. I understand that I am financially responsible to Prevea Health for charges not paid by my insurance or other payer, to the extent allowed by applicable law. I understand all balances are due within 30 days. In the event of default, I agree to pay all costs of collection including reasonable attorney fees.

PHOTOGRAPHS, AUDIO/VIDEO RECORDINGS: I understand that photographs, videotapes, recordings, digital or other images may be recorded by Prevea Health to document my care. I understand that Prevea Health will retain the ownership rights to these images however; I may be allowed to access/listen to them or obtain copies whenever possible. Images that identify me will be released and/or used outside the organization only upon written authorization from me or my legal representative or as allowed by law.

Signature of Patient or Guardian _____ Date _____

Patient Label

Printed Name of Patient or Patient Representative (e.g. guardian) _____ Relationship to Patient _____

SV

PREVEA health

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

Name | Address | City | State | Zip

Date of Birth | Daytime Phone | Previous Name(s)

2) AUTHORIZES:

Name of Health Care Provider/Plan/Other

Address | Fax # of Health Care Provider

3) TO DISCLOSE TO: ☑ Self, Delivery Options: ☐ Pick up ☐ Mail to address above ☐ View on-site ☐ Electronic Format

☐ E-mail to: _____

If the e-mail address is shared with another person or the e-mail password is known to others, consider other methods of delivery. HSHS will automatically send e-mail through encrypted/secured means unless otherwise directed. Unencrypted email poses some level of risk, e.g., a third party could see the information without consent. HSHS is not responsible for unauthorized access to unencrypted email containing confidential information or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information in unencrypted electronic format or e-mail. By selecting the unencrypted e-mail option I acknowledge the risks have been communicated and I accept these risks. ☐ Unencrypted Email

☐ To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send To: ☑ Prevea Health

Name of Health Care Provider/Plan/Other

715 717 6677

Address | Fax # of Health Care Provider

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____ If left blank, only information from the past two (2) years will be disclosed. (Month/Year) (Month/Year) Note: Future dates will not be honored.

5) INFORMATION TO BE DISCLOSED:

☑ Abstract of record/Pertinent records ☑ History & physical ☑ Discharge summary
☑ Emergency Department report ☑ Consultation reports ☑ Operative reports
☑ Radiology/Imaging reports ☑ Laboratory/Pathology ☑ EKG
☑ Radiology/Imaging films/CD ☑ Progress notes _____ ☐ Billing records _____
Specific records and/or information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date/event: patient withdraws or graduates from North Cedar Academy
Or if this item is left blank, the authorization will expire in (1) year from the date signed.

7) PURPOSE (check all that apply – copy fees may apply): ☑ Patient Request ☑ Continuing Care
☐ Legal Investigation/Action ☐ Insurance Eligibility/Benefits ☐ Other: _____

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the following rights: to inspect and/or receive a copy of the health information; to have information be used and/or disclosed by this Authorization; if I agree to sign this Authorization, I will be provided with a copy of it; I may be charged a fee for record copies; I am under no obligation to sign this form and treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this Authorization; Authorization may be needed to release information to payers for certain mental health services, AODA services and/or HIV testing, however, I can refuse to sign this Authorization form for such purposes but I may be responsible for paying the entire bill for such services; I may revoke this Authorization at any time by notifying the authorizing provider's health information department, as listed above, in writing and will not be effective as to uses and/or disclosures already made in reliance upon this Authorization, needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage, or to submit a claim to third party payers as provided in this Authorization after having provided treatment in reliance upon this Authorization; the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient and may no longer be protected by applicable federal privacy law, Wisconsin or Illinois Law. *Federal Regulation (42 CRF, Part 2)/AODA prohibits any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by regulations. However, I understand that any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy standards. I understand that if there is not an existing treatment provider relationship with the party to whom information is being sent, a general designation may be used. I understand that I may request a list of entities to which my information has been disclosed from the "Send To" entity listed above.*

9) SIGNATURE OF PATIENT: _____ Date: _____ and/or
SIGNATURE OF LEGAL REPRESENTATIVE: _____ Date: _____
WITNESS SIGNATURE (AODA/Mental Health Only): _____ Date: _____
If signed by a person other than the patient, complete the following:
1) Individual is: ☑ a minor (AODA exception) ☐ legally incompetent or incapacitated ☐ deceased
2) Legal authority: ☐ parent* ☐ legal guardian ☐ activated POA for Health Care ☐ next of kin/executor of deceased
*By signing above, I hereby declare that I have not been denied physical placement of this child.

OFFICE USE ONLY: Signature/ID verified: ☐ Yes ☐ No Date/Time Released: _____ Completed by: _____ Medical Record Number: _____

Original: Medical Record Copy: Patient A photocopy of this authorization will have the same force and effect as the original

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 6/2020)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION.** State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission.** The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

Step 1 **PERSONAL DATA** **PLEASE PRINT**

Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR **(X)** except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE MM/DD/YYYY	SECOND DOSE MM/DD/YYYY	THIRD DOSE MM/DD/YYYY	FOURTH DOSE MM/DD/YYYY	FIFTH DOSE MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine *Vaccine is required only if your child has not had chickenpox disease. See below:*					

Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known:
☐ YES _____ Year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply)
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
If YES, provide laboratory report(s)

Step 3 **REQUIREMENTS**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 **COMPLIANCE DATA**

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

— **Or** —

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has **NOT** received **ALL** the required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations _____

_____ _____
SIGNATURE - Physician Date Signed

☐ **For religious reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

☐ **For personal conviction reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

Step 5 **SIGNATURE**

This form is complete and accurate to the best of my knowledge. Check one: (**I do** ☐ **I do not** ☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

_____ _____
SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed

VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry.

CHART NUMBER

Patient's Name (Last, First, Middle Initial) Include maiden name if married.	Mother's Maiden Name (Last, First, Middle Initial)

Address	P. O. Box	City	County	State	Zip Code

Email address (If applicable)	Home Telephone Number	Work Telephone Number (Include extension number)

Social Security Number	Date of Birth (mm/dd/yyyy)	Patient Birth State/Country	Gender
			☐ Male ☐ Female

Race (Check one)
☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian / Pacific Islander
☐ White ☐ Other

Ethnicity (Check one)
☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Eligibility Status (Check all that apply) **This section must be completed.**
☐ **Native American** ☐ **Medicaid Eligible** ☐ **Badger Care** ☐ **No Health Insurance** ☒ **Insured, Vaccines Covered** ☐ **Insured, Vaccines Not Covered**

Name of Physician	Name of Insurance Provider	Name of School or Day Care (If applicable)

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)	Relationship to Patient

Is reminder or recall contact allowed?	Would you like reminder/recall sent to you?
☐ Yes ☐ No	☐ Yes ☐ No

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

I give permission to share my child's immunization records including those provided to School(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. Check here ONLY if you do NOT give your permission ☐ .

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf.	Date Signed
X	