NORTH CEDAR ACADEMY

6/13/22

Welcome Back to North Cedar Academy!

It is hard to believe we are looking at school already this fall for 2022-2023 school year. I hope your son or daughter are doing well and eager to return to NCA this fall. All of us here at NCA are looking forward to seeing your child again. My first and foremost concern is the health and well-being of our students, staff, and the Ladysmith community. NCA continues to follow the COVID -19 guidelines of the CDC, State of Wisconsin, and the Rusk County Department of Health & Human Services.

I have included in this mailing the necessary forms needed for this upcoming school year. Please complete and return them to NCA.

1. NCA Student and Parent Information Form
2. Student Medical Information (note any new changes in your child's health)
3. Authorization of Prescription Medications (if your child is not on any prescriptions disregard this form
4. Marshfield Medical Center Consent to Treatment of Minors
5. Rusk County Health and Human Services Optional Vaccine Form

If your child received any vaccinations during the summer months please let us know. I did include the Rusk County Health and Human Services Optional Vaccine Form if you would like your son and daughter to receive any of them such as the Flu vaccine etc. These optional vaccines are not required but are highly encouraged if your son or daughter plans to go onto college in the future.

If you have, any questions please feel free to contact me at 715-532-0201, Ext. 230 or email me at ckrings@northcedar.net. Wishing you a healthy and safe summer!

Sincerely yours,

Cynthia Krings RN, BSN

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

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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

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:** _____

MARSHFIELD CLINIC HEALTH SYSTEM

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 _____ Appointee's phone number 715-532-0201 / 928-202-1096

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

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

☐ Emergent or urgent care(including mental health treatment) at any of the following facilities when I cannot be reached: Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations.

☐ 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 any of the following facilities: Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations

☑ 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, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations 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: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

Additional copy to patient

Rusk County Health & Human Services

- *Behavioral Health Services*
- *Children & Family Services*
- *Child Support Services*
- *Economic Support Services*

Public Health Department

311 Miner Ave. E., Suite C220

ɔle: (715) 532-2299 Ladysmith, WI 54848 Fax: (715) 532-2217

Web: www.ruskcounty.org/services/hhs_phealth.asp

- *Health Services*
- *Adult Services*
- *Senior Services/ADRC*
- *Veterans Services*

(For deaf and/or hard of hearing, please call us through Wisconsin Relay 711)

Child's Name: _____

OPTIONAL VACCINES

Please check the box next to ***each*** vaccine you wish your child to receive

The following vaccines are NOT REQUIRED by the State of Wisconsin however they are HIGHLY RECOMMENDED

☐ **HUMAN PAPILLOMAVIRUS (HPV)** – see back for description

☐ **HEPATITIS A** - see back for description

☐ **INFLUENZA (FLU)** - see back for description

☐ **MENINGOCOCCAL** – see back for description

- ☐ Meningococcal conjugate vaccines (Menactra® and Menveo®)
- ☐ Serogroup B meningococcal vaccines (Bexsero® and Trumenba®) {target age 16 – 18}

X _____ ___/___/___

Parent/Guardian Date

11/21

HPV - Human papillomavirus (HPV) is a very common virus that can lead to cancer. Nearly 80 million people—about one in four—are currently infected with HPV in the United States. About 14 million people, including teens, become infected with HPV each year. Over 30,000 people in the United States each year are affected by a cancer caused by HPV infection. While there is screening available for cervical cancer for women, there is no screening for the other cancers caused by HPV infection, like cancers of the mouth/throat, anus/rectum, penis, vagina, or vulva. HPV vaccination provides safe, effective, and lasting protection against the HPV infections that most commonly cause cancer.

HEPATITIS A - Hepatitis A is a liver disease caused by the hepatitis A virus (HAV). Hepatitis A can affect anyone. Vaccines are available for long-term prevention of HAV infection in persons 1 year of age and older. Good personal hygiene and proper sanitation can also help prevent the spread of hepatitis A.

FLU - Influenza (flu) is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. It can cause mild to severe illness, and can lead to hospitalization and death. Every year in the United States, millions of people are sickened, hundreds of thousands are hospitalized and thousands or tens of thousands of people die from the flu. Anyone can get the flu (even healthy people) and serious problems related to the flu can happen at any age, but some people are at higher risk of developing serious flu-related complications if they get sick. This includes people 65 years and older, people of any age with certain chronic medical conditions (such as diabetes, asthma, or heart disease), pregnant women, and young children. The best way and most important step to prevent the flu is by getting a flu vaccine each year. CDC recommends that everyone 6 months of age and older get a flu vaccine each year. Flu vaccination can reduce flu illnesses, doctors' visits, and missed work and school due to flu, as well as prevent flu-related hospitalizations. CDC recommends that everyone 6 months of age and older get a flu vaccine every year. An annual flu vaccine is the first and best way to protect against flu.

MENINGOCOCCAL - Vaccines are available that can help prevent meningococcal disease, which is any type of illness caused by *Neisseria meningitidis* bacteria. All 11 to 12 year olds should be vaccinated with a meningococcal conjugate vaccine. A booster dose is recommended at age 16 years. Teens and young adults (16 through 23 year olds) also may be vaccinated with a serogroup B meningococcal vaccine. In certain situations, other children and adults could be recommended to get meningococcal vaccines.

CDC recommends routine **meningococcal conjugate vaccination** for:

- All preteens and teens at 11 to 12 years old with a booster dose at 16
- Children and adults at increased risk for meningococcal disease

CDC recommends routine **serogroup B meningococcal vaccination** for:

- People 10 years or older at increased risk for meningococcal disease
- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed
- Anyone with a rare immune system condition called "persistent complement component deficiency"
- Anyone taking a drug called eculizumab (also called Soliris®)
- Microbiologists who routinely work with isolates of *N. meningitidis*

PREVEA health

Patient label

COVID 19 Vaccination Consent

PATIENT NAME_____ **(please print)** **Date of Birth:** _____
mm /day /year

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **While the FDA has not approved and continues to evaluate its safety and effectiveness, the FDA has authorized the emergency use of it to prevent COVID 19.**

The COVID 19 vaccine is a series of one (1) or two (2) injections, depending on the manufacturer. If two vaccinations are required, the vaccinations must be spaced apart based on manufacture and FDA guidelines. Please ensure that you can complete the series before consenting to this vaccine administration.

All vaccines have risks. Possible side effects of the COVID 19 vaccine, while generally inconsequential in adults, can include:

1. Pain, redness or swelling around the vaccination site.
2. Fever, malaise, headache, fatigue, chills joint pain and muscular aches. There is a remote risk of a severe allergic reaction.
3. There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely.

Attached is a Fact Sheet from the manufacturer of the vaccine. Please read the attached Fact Sheet completely and carefully.

Individuals who are currently ill and/or have a fever should not be vaccinated until symptoms have subsided.

CONSENT

I consent to the administration of up to two injections of the COVID-19 virus vaccine. I have read the above statement pertaining to COVID-19 virus vaccine and the attached Fact Sheet from the manufacturer. I have been advised of and understand the risks, side effects, benefits and alternatives to receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in myself. I have been advised and understand the vaccine is a series of one or two injections and I intend to complete the series vaccination. **I understand that I am receiving the vaccine voluntarily and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that I will not realize the benefit of the vaccine if I decline to receive the second injection.**

Signature:

_____ _____ _____

Signature of Patient or Legal Representative **Date** **Printed name of Legal Representative (if patient is unable to sign)**

_____ _____

Reason patient cannot sign (if relevant) **Relationship of Legal Representative to Patient (if relevant)**

I understand that: (i) I have the right to receive a copy of this authorization; (ii) I am under no obligation to sign this authorization form and treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this authorization; (iii) I may revoke this authorization by contacting Health Information Management, but revocation of this authorization will not be effective as to uses and/or disclosures already made in reliance upon this authorization; and (iv) Information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by applicable federal privacy law, Illinois or Wisconsin laws.

This authorization will expire one year after the date of signature.

Signature:

_____ _____ _____

Signature of Patient or Legal Representative **Date** **Printed name of Legal Representative (if patient is unable to sign)**

_____ _____

Reason patient cannot sign (if relevant) **Relationship of Legal Representative to Patient (if relevant)**

PREVEA health

Patient label

COVID 19 Vaccination Consent for Minors (16-17 years old)

PATIENT'S NAME_____ **(please print)** **Date of Birth:** _____

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **While the FDA has not approved and continues to evaluate its safety and effectiveness, the FDA has authorized the emergency use of it to prevent COVID 19.**

The Pfizer COVID 19 vaccine is a series of ~~two (2) injections~~ BOOSTER VACCINE. The vaccinations must be spaced apart based on manufacture and FDA guidelines. Please ensure that the above-named patient can complete the series before consenting to this vaccine administration.

All vaccines have risks. Possible side effects of the COVID 19 vaccine, while generally inconsequential, can include:

1. Pain, redness or swelling around the vaccination site.
2. Fever, malaise, headache, fatigue, chills joint pain and muscular aches. There is a remote risk of a severe allergic reaction.
3. There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely.

Attached is a Fact Sheet from Pfizer. Please read the attached Fact Sheet completely and carefully.

Individuals who are currently ill and/or have a fever should not be vaccinated until symptoms have subsided.

CONSENT

I, the parent or legal guardian of the patient, hereby consent to the administration of two injections of the Pfizer COVID-19 virus vaccine for the above-named patient. I have read the above statements pertaining to the Pfizer COVID-19 virus vaccine and the attached Fact Sheet. I have been advised of and understand the risks, side effects, benefits and alternatives to the above-named patient receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in the above-named patient. I have been advised and understand the vaccine is a series of two injections and I intend for the above-named patient to complete the series of injections. **I understand that I am voluntarily consenting to the above-named patient to receive the vaccine and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that the above-named patient will not realize the benefit of the vaccine if I refuse or decline to have the above-named patient receive the second injection.**

I understand that Prevea may contact me to confirm my consent in Prevea's discretion, to obtain additional information that Prevea may need pertaining to the above-named patient, or otherwise as necessary in the event of an emergency. I further understand that Prevea may decline to provide the vaccination if the requested Contact information is not provided below.

Signature:

_____ _____ _____

Signature of Parent or Legal Guardian | Date | Printed name of Parent or Legal Guardian

_____

Parent or Legal Guardian (circle one)

Contact Information:

Cell Phone: _____

Home Phone: _____

Office Phone: _____