# NORTH CEDAR ACADEMY

1500 Port Arthur Road, Ladysmith, Wisconsin 54848, USA
**Tel:** +1 (715) 609-1723, **Fax:** +1 (715) 532-9916
admissions@northcedar.net | northcedar.net


## CAMPER REGISTRATION

*Please Print or Type*

## CAMPER APPLICANT INFORMATION

*Date of Application* _____ (MM/DD/YYYY) *Date of entrance to North Cedar Academy:* Fall ☐ Spring ☐ Summer ☐ *Year* _____ *Grade level during Camp* _____

*Applicant's Full Name* _____ (Given Name(s)) _____ (Family name/Surname) *Preferred Name or Nickname* _____

*Gender* _____ *Date of Birth* _____ (MM/DD/YYYY) *City of Birth* _____ *Country of Birth* _____

*Country of Citizenship* _____ *E-mail Address* _____ *Mobile Phone* _____ (Include country and city/area codes)

*WhatsApp* _____ *WeChat* _____ *Home Phone* _____ (Include country and city/area codes) *Preferred Method of Contact* _____

*Student's Physical Address* _____ (Include building number, street, district, and apartment number if applicable, in the format it is typically written in your country.) *City* _____

*State or Province* _____ *Zip/Postal Code* _____ *Country (if not U.S.)* _____

*How did you hear about NCA?* _____ *Consultant Company* _____ (If applicable) *Consultant Office* _____ (If applicable) (List city the office is located in.)

*Consultant Name* _____ (If applicable) *Email* _____ (If applicable) *Phone* _____ (If applicable) *Web URL* _____ (If applicable)

***Camper's Program of Choice:*** *EFL/ESL and English Placement Testing Prep* ☐ *ACT/SAT Prep and College Readiness* ☐

*Have you ever received psychological or psychiatric counseling?* Yes ☐ No ☐

*Have you ever been tested for a learning disability?* Yes ☐ No ☐

*Are you now or have you ever received special education support services and/or been on an Individual Education Plan (IEP)?* Yes ☐ No ☐

***IF** you answered **Yes** to any of the above questions, please give details below and **have complete documentation sent to North Cedar Academy:***

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## FAMILY INFORMATION

*Name of Parent 1* _____ (Given Name(s)) _____ (Family name/Surname) *Preferred Name* _____ *Date of Birth* _____ (MM/DD/YYYY)

*E-mail Address* _____ *Mobile Phone* _____ (Include country and city/area codes) *Work Phone* _____ (Include country and city/area codes) *WhatsApp* _____

*WeChat* _____ *Preferred Method of Contact* _____ *Lives with Student:* Yes ☐ Yes, part-time ☐ No ☐

*Occupation or Position* _____ *Name of Business* _____ *Business Address* _____

*Business Phone* _____ *Business E-mail* _____ *Languages Spoken* _____

*Where should camp materials be sent? Student* ☐ *Parent 1* ☐ *Parent 2* ☐ *Consultant* ☐ *Other* ☐ : _____

*If parents are divorced, separated, or no longer have custody, who has legal custody of the student?* _____

*Name of Parent 2* _____ (Given Name(s)) _____ (Family name/Surname) *Preferred Name* _____ *Date of Birth* _____ (MM/DD/YYYY)

*E-mail Address* _____ *Mobile Phone* _____ (Include country and city/area codes) *Work Phone* _____ (Include country and city/area codes) *WhatsApp* _____

*WeChat* _____ *Preferred Method of Contact* _____ *Lives with Student:* Yes ☐ Yes, part-time ☐ No ☐

*Occupation or Position* _____ *Name of Business* _____ *Business Address* _____

*Business Phone* _____ *Business E-mail* _____ *Languages Spoken* _____

**Emergency Contacts (E.C.) -** Please include at least one that is located in the United States, if possible.

Name of E.C. #1 _____ *Relation to Camper* _____ *Phone* _____ *Email* _____

Name of E.C. #2 _____ *Relation to Camper* _____ *Phone* _____ *Email* _____

Name of E.C. #3 _____ *Relation to Camper* _____ *Phone* _____ *Email* _____

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**CAMPER REGISTRATION**
*Please Print or Type*

## MEDICAL INFORMATION

**Please mark the following allergies that apply to this camper:**

Allergies, non life-threatening environmental, medication, food, etc. ☐

Allergies, SEVERE or life-threatening FOOD ☐ Allergies, SEVERE or life threatening environmental, medication, insect, etc. ☐

**List the allergen(s) and describe the allergic reaction(s):**

_____

_____

_____

**Do you follow a special diet for medical, personal, or religious reasons? Yes ☐ No ☐**

**If yes, please describe:** _____

**Please mark all that apply to this camper:**

Contacts/Glasses ☐ Hard of Hearing/Deaf ☐ Recent Head, Back, or Neck Injury ☐ Seizure Disorder ☐ Asthma ☐ Existing Heart Condition ☐ Diabetes ☐ Diarrhea, Constipation, or GI Issues ☐ Skin Conditions ☐ Joint Problems (recent or chronic) ☐ Previous Hospitalizations Previous Surgeries ☐ Chronic or Recurring Illness (not listed) ☐ Emotional, Social, Learning, or other Mental Health Concerns ☐ Sleep related issues ☐ Activity Restrictions ☐ Other Concerns Not Listed ☐

**Explain any check marks above here:**

_____

_____

_____

**Will you be bringing your own sunscreen to camp with you?** Brand: _____

**Do you authorize the use of sunscreen provided by NCA?** Yes ☐ No ☐

**Will you be bringing your own mosquito/bug repellent to camp with you?** Brand: _____

**Do you authorize the use of bug repellent provided by NCA?** Yes ☐ No ☐

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**CAMPER REGISTRATION**
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## MEDICATIONS, IMMUNIZATIONS

The following list of medications may be administered on an as needed basis per standing orders. Any medications NOT listed below require a separate form providing authorization from the camper's primary care provider. **Please mark any of the following medications you DO NOT authorize staff to administer to the camper.**

Tylenol (Acetaminophen) ☐ Advil (Ibuprofen) ☐ Aleve (Naproxen Sodium) ☐ Benadryl (Diphenhydramine) ☐ Sudafed (Pseudoephedrine) ☐
Cough Suppressant/Expectorant ☐ Cough Drop/Throat Lozenge ☐ Tums/Pepto-Bismal (Antacid) ☐ Anti-Diarrheal ☐ Anti-gas (Simethecone) ☐
Allergy Eye Drops ☐ Anbesol/Orajel (Analgesic) ☐ Antibiotic Ointment ☐ Anti-Fungal Cream ☐ Antiseptic Spray ☐ Burn Gel with Lidocaine ☐
Anti-itch (Caladryl) ☐ Calamine Lotion ☐ Chloraseptic Throat Spray ☐ Hydrocortisone Cream ☐ Hydrogen Peroxide ☐ Topical Muscle Rub ☐

**If any of the following medications are taken on a regular basis, BRING it to camp in original packaging:**

Zyrtec (Cetirizine) ☐ Claritin (Loratidine) ☐ Allegra (Fexofenadine) ☐ Xyxal (Levocetirizine Dihydrochloride) ☐ OTC Allergy Nasal Spray ☐
Melatonin ☐ Colace/Miralax (Stool-softener) ☐ Multivitamin ☐ Lactaid ☐

**Please indicate if your child is currently taking any medication (or will be) during camp. Please list below:**
(Note: Must be accompanied by Prescribed Medication Authorization Form signed by physician, and translated if not in English.)

_____

_____

**Immunizations:** Campers coming from outside the US must have a copy of their immunization record, completed in or translated into English.

**Is camper exempt from immunizations because of personal, medical, or religious reasons?** Yes ☐ No ☐ If yes, list exemptions below:

_____

_____

**What was the month/year of the camper's last tetanus shot?** _____

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## CAMPER REGISTRATION

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## PHYSICIAN & INSURANCE INFORMATION (SEND COPY OF INSURANCE CARD)

**Does the camper have a Primary Care Provider/Physician?** Yes ☐ No ☐

If no, provide the name of the last physician/facility the camper was seen by, with the phone number & date of visit: _____

**PCP/Physician Name** _____ **Phone #** _____

**Name of Insurance Provider** _____ **Claims Phone #** _____

**Claims Address** _____

**Policy Holder's Name** _____ **Policy #** _____

**Policy Holder's Date of Birth** _____ **Group #** _____

## MEDICAL RELEASE STATEMENT (READ & SIGN)

This health history is correct and complete as far as I know. The completed health information form may be printed for trips outside of NCA campus.

I agree that NCA, its Agents, officers, employees, trustees and volunteers will not be liable for any injury, death, damage and/or loss to myself or my child, and/or anyone claiming on my or my child's behalf, and I further agree to hold harmless, indemnify and defend NCA, its officers, staff, agents, employees, trustees and volunteers for and from any and all liability, claims, losses, injuries, expenses, fees, and/or damages arising out of any injury, illness or death to myself or my child or property damage during my or my child's attendance at NCA. The minor child herein has permission to engage in all camp activities as described on the activities waiver unless otherwise noted on the health information form. While NCA has safety protocols in place to manage allergen related issues, I understand that a minor with specific allergies or intolerance has a role and responsibility in the avoidance of the known allergen. I agree to educate my child, who has allergies or intolerance, to ask questions, read labels, or abstain from the substance in question when in doubt.

I hereby give permission the the camp to provide basic first aid, and administer prescribed medications as authorized by my child's PCP. I also give permission for NCA to administer camp stocked over-the-counter medications on an "as needed basis", as indicated on the health form, and as directed by trained staff. I give permission to NCA to seek emergency medical treatment including ordering x-rays or routine tests. In the event of an emergency, I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the practitioner selected by the camp to secure and administer treatment, including hospitalization, for my child.

I hereby authorize NCA's officials to share health information and health history with the other staff members on a need-to-know basis. This includes the camp and program directors, counselors, cooks, and nursing staff that have the minor in their care. The purpose of this disclosure is for the necessary staff to be prepared in advance for any medical emergencies. I agree to the release of any records necessary for insurance purposes. The health information that may be disclosed will be from the Health Information fields in the registration packet or otherwise provided by the camper or their guardian(s). I authorize release of medical information to the local medical practitioner for necessary treatment while attending camp. I also authorize the release of medical information from my child's PCP office to NCA or the local practitioner if necessary. This authorization is valid for the _____ (year) Summer. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that this information is released to aid in the treatment and care of my child.

**Parent/Guardian Signature** _____ **Date** _____

# NCA Summer Camp
# Release and Waiver Agreement

**Name of Camper (printed):** _____ (hereinafter "Camper") **Age:** _____

If Camper is UNDER 18, **Name of Parent/Legal Guardian (printed):** _____

1. **This Release and Waiver Agreement (hereinafter "Agreement") is made this day** _____ (MM/DD/YYYY) **by and between:** (i.) Camper, if Camper is over the age of eighteen (18), and any of Camper's heirs, beneficiaries, personal representatives, or assigns; OR (ii.) Guardian, if Camper is under the age of eighteen (18), and any of Camper's and Guardian's respective heirs, beneficiaries, personal representatives, or assigns (hereinafter "Releasors"):

   AND

   North Cedar Academy, LLC., & their administrators, directors, officers, agents, employees, and volunteers (hereinafter "Releasees").

2. **Assumption of the Risk and Safety:** In consideration of being allowed to participate in any activities at North Cedar Academy, including for the date(s) of: _____, Releasors hereby acknowledge and assume the risks of injury or damage, including but not limited to property damage, personal injury, and/or death, involved in participating in any activity offered by North Cedar Academy including, but not limited to: paintball (including the use of compressed air paintball markers), skateboarding, zip line, high and low ropes course, climbing tower, challenge course, swimming, camping out, archery, inflatables, hiking, go-karting, amusement/adventure park rides and tree climbing, as well as travel to the aforementioned. Releasors further understand that participation in these activities contains risks that Releasors appreciate and voluntarily assume. Releasors give their express permission for Camper to participate in the program as designed by North Cedar Academy. Releasors further agree that any individual, including minor children, who intend to participate in any activity coordinated by North Cedar Academy shall participate in all safety training and wear all safety equipment provided by North Cedar Academy or the venue for any activities that require it.
3. **Waiver of Liability:** Releasors hereby release, remise, acquit, and forgive Releasees from any and all liability of any nature, including negligence, breach of contract, for any and all injury or damage (including but not limited to property damage, personal injury, illness, paralysis, and/or death) to Releasors as the result of Releasors' participation in any of the activities coordinated by North Cedar Academy, including but not limited to any such injury or damage resulting from the sole negligence of Releasees, but not including any such injury or damage resulting from the intentional actions and/or gross negligence of Releasees.
4. **Waiver of Claims:** Releasors hereby expressly waive any claim, lawsuit, complaint, charge, or cause of action against Releasees for any and all injury or damage (including but not limited to property damage, personal injury, illness, paralysis, and/or death) to Releasors as a result of Releasors' participation in any of the activities at North Cedar Academy, including but not limited to any such claim, lawsuit, complaint, charge, or cause of action resulting from the sole negligence of Releasees, but not including any claim, lawsuit, complaint, charge, or cause of action resulting from the intentional actions and/or gross negligence of Releasees.
5. **Indemnity:** In addition to and not in substitution of any other indemnification obligations of Releasors under this Agreement and/or applicable law, to the fullest extent permitted by law, Releasors shall defend, indemnify, & hold harmless Releasees from & against any & all claims, damages, expenses, costs, fines, penalties, attorneys' fees, liens, mechanic's liens, suits, judgments & any other liabilities of any kind, including, but not limited to, liabilities for property damage, personal injury, or death arising out of or resulting from or in connection with any acts or omissions of Releasees that arise out of or relate to Releasors' participation in any activities at North Cedar Academy, regardless of whether or not caused in part by Releasees.
6. **Releasors' Understanding:** Releasors agree that that this Agreement is not the product of grossly unequal bargaining power, and that Releasors have had a full and fair opportunity to review the provisions of this agreement and seek legal counsel regarding the legal ramifications of this Agreement. Releasors further agree that this Agreement does not amount to or relate to a transaction affecting the public interest. Releasors expressly acknowledge that participation in any camp or activity at North Cedar Academy is entirely voluntary, and that Releasors assent to the terms of this Agreement as a precondition to being permitted to participate in any activity at North Cedar Academy. Releasors expressly acknowledge that they are completely waiving their right to sue Releasees for any reason, including negligence or any legal basis for any damages that Camper and/or Releasors may suffer as a result of participation in any activity at North Cedar Academy (except for damages caused by Releasees' intentional acts or gross negligence). If this Agreement is signed by Guardians, Guardians expressly acknowledge that they are completely waiving their right to sue Releasees for any damages that Guardians or their minor child, Camper, may suffer as a result of participation in any activity at North Cedar Academy (except for damages caused by Releasees' intentional acts or gross negligence).
7. **Agreement Binding upon Heirs and Beneficiaries:** It is understood and agreed that this waiver, release and assumption of risk is to be binding on my heirs, beneficiaries, and assignees.
8. **Governing Law:** The agreement is deemed to be entered into the State of Wisconsin and to be governed and enforced pursuant to the law of the State of Wisconsin.
9. **Jurisdiction:** All claims or disputes arising out of or related to this agreement or from Camper's participation in any activity coordinated by North Cedar Academy shall be brought and maintained in the courts of Rusk County, Wisconsin. Releasors expressly consent and submit to the exclusive jurisdiction of such courts.
10. **Severability:** If any provision in this Agreement shall be held invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.
11. **Transportation:** Releasors give their permission to North Cedar Academy to transport any camp Camper from one activity to another by an authorized member of the North Cedar Academy staff or contracted transportation provider and within an authorized vehicle, if deemed necessary by North Cedar Academy.
12. **Consent to Be Photographed/Filmed:** Releasors give permission and consent to be photographed and/or filmed during activities and while on premises at North Cedar Academy. Releasors further give permission and consent that any such photographs may be published and used by North Cedar Academy and its agents, to illustrate and promote the camp experience, North Cedar Academy and its programs.

**I HEREBY CERTIFY THAT I HAVE READ & UNDERSTAND ALL OF THE FOREGOING TERMS OF THIS AGREEMENT & EXPRESSLY ASSENT THERETO:**

If Camper is 18 or over, Signature of Camper: _____ Date: _____

If Camper is UNDER 18, Signature of Parent/Guardian: _____ Date: _____

# 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: Camp Counselors, Camp 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 31st day of July , 20 24
- ☐ Until you cancel this authorization in writing.
- ☐ Until the following event occurs, specify event _____
- ☐ 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**

  