WOODWARD ACADEMY

PARENT/GUARDIAN
INFORMATION/CONSENT PACKET

MAIL OR FAX TO:

Woodward Academy
% Admissions
1251 334th St.
Woodward, Iowa 50276
Phone: 515-438-3481
Fax: 515-438-3489
E-Mail: avanwinkle@wwacademy.com

Please have paperwork completed prior to admission

WOODWARD ACADEMY
PERSONAL ITEMS LIST
CLOTHING NEEDS

CLOTHING REQUIRED	90 DAY BOOTCAMP	4-6 MONTH COMM.RES.	9-18 MONTH SEX OFFENDER
MENS BRIEFS no boxers	8 pair	8 pair	10 pair
WHITE ATHLETIC SOCKS	8 pair	8 pair	10 pair
WHITE CREW NECK T-SHIRTS	3	3	8
SANDAL TYPE SHOWER SHOES (must be able to wear socks,no toe separator)	0	1pair	1 pair
BATH ROBE	1	1	1
ATHLETIC SUPPORTERS (JOCKS)	3	2	2
SWEATSHIRTS	2 (navy blue)	2	4
SWEATPANTS	2 (navy blue)	2	4
ATHLETIC SHORTS	0	3	4
EVERYDAY SHIRTS	0	3	8
STOCKING CAP/GLOVES	0	1 set	1 set
JACKET (SPRING/FALL)	0	1	1
WINTER COAT	0	1 if in season	1 if in season
NNING/CROSS TRAINING SHOES	1 pair	1 pair	1 pair
APPROPRIATE FITTING JEANS	0	2 PAIRS	5 PAIR

- STUDENTS IN THE 4-6 MONTH CR PROGRAM AND THE 9-18 MONTH SO PROGRAM MAY ALSO BRING DRESS/KHAKI PANTS AND DRESS SHIRTS.

ALL CLOTHING AND PERSONAL ITEM SHOULD BE BROUGHT WITH HIM ON ADMIT OR BE WITH THE STUDENT WHEN STAFF PICK THEM UP IF POSSIBLE.

ALL STUDENTS SHOULD ALSO BRING:
1) US POSTAL Stamps and envelopes for letter writing
2) Appropriate family photos
3) THREE MONTHS SUPPLY OF: shampoo, deodorant, soap, lotion, toothpaste, toothbrush, shaving cream, comb, soap dish.
(No glass bottles)
4) A PHONE CARD

Woodward Academy staff will send home or store any items that are deemed inappropriate to the program.
EXAMPLES:
1) Any gang related items
2) Any clothing items with inappropriate slogans/comments
3) Clothes must fit appropriately, **no oversized clothing**
4) Radios, CD players, and Valuables are allowed only at certain phases of the program
5) Watches and Necklaces only allowed at certain phases of program, do not bring at admit

PROVIDERS FOR WOODWARD ACADEMY

(PARENT/GUARDIAN - THIS SHEET IS FOR YOU TO KEEP AS A REFERENCE)

Physician:	U of I Family Care Division of University of Iowa Community Medical Services 616 10th Street Perry, Iowa 50220 515-465-3553
Hospital:	Dallas County Hospital 610 10th Street Perry, Iowa 50220 515-465-3547
Psychiatry:	Dr. Terry Augspurger, M.D. Susan Smith, ARNP, CS * consulting mental health professionals who provide services through weekly on campus visits
Dentist:	Dr. Joel Wright & Dr. Greg Steffen 1305 2nd Street Perry, Iowa 50220 515-465-3501
Podiatry:	Dr. Todd Miller 612 10th Street Perry, Iowa 50220 515-465-5688
Optometry:	Eye Care Associates 1313 2nd Street Perry, Iowa 50220 515-465-4203
Pharmacy:	Medicap Pharmacy Madrid, Iowa 877-795-4252
Audiology:	Michael Gentz 1401 50th Street Regency #2, Suite 112 West Des Moines, Iowa 50266 800-246-1891

TO PARENTS AND GUARDIANS:

STUDENT NAME: _____

Comprehensive mental, physical, and emotional health care require a thorough review of the child's health background. Please complete this now to the best of your knowledge. The registered nurse will review it with the student and with you if necessary to clarify any questions. Please inform the nurse of any significant health problems. Thank you for your assistance.

ALLERGIES: **FOOD** _____
DRUGS_____
OTHER_____

YES	NO	**EYE/EAR/NOSE/THROAT**
		EYE INJURIES_____
		FREQUENT EYE INFECTIONS_____
		EAR INFECTIONS_____TUBES: R L WHEN:_____ REMOVED:_____
		EAR DISCHARGE_____ RINGING IN EARS_____
		NASAL FRACTURE_____DEVIATED SEPTUM_____
		CHRONIC NOSEBLEEDS_____
		SINUS TROUBLE_____
		FREQUENT COLDS_____
		FREQUENT TONSILLITIS/ STREP THROAT_____
		SWOLLEN GLANDS_____
		MOUTH/ TONGUE BLEEDING/ SORES_____
		OTHER_____
		RESPIRATORY
		ASTHMA/ WHEEZING/ SHORTNESS OF BREATH_____
		AGE OF ONSET_____CURRENT TREATMENT_____
		TUBERCULOSIS_____ VALLEY FEVER_____
		WHOOPING COUGH_____
		PNEUMONIA_____ BRONCHITIS_____
		CHRONIC COUGH_____ COUGHING BLOOD_____
		OTHER_____
		CARDIOVASCULAR
		EKG (WHEN/ WHERE)_____
		IRREGULAR HEART BEAT_____
		CHEST PAIN_____
		CONGENTIAL HEART DISEASE_____
		RHUEMATIC FEVER_____
		OTHER_____
		EXERCISE INTOLERANCE_____
		HEMATOLOGY
		BLOOD TRANSFUSIONS_____
		I.V. DRUG USE_____
		DRUG REACTIONS_____
		BLEEDING DISORDERS_____
		ANEMIA_____
		SICKLE CELL TRAIT_____

YES	NO	
		GASTROINTESTINAL
		CHRONIC INDEGESTION
		CHRONIC NAUSEA/ VOMITING
		ANOREXIA/ BULEMIA
		ULCERS
		ABDOMINAL PAIM
		HEPATITIS
		GALL BLADDER
		CHRONIC CONSTIPATION/ DIARRHEA
		LAXATIVE USE
		SOILING/ ENCOPRESIS
		ENDOCRINE
		THYROID DISORDER
		DIABETES
		OTHER
		NEUROLOGIC
		EEG (WHEN/WHERE) X-RAY (WHEN/WHERE)
		MRI (WHEN/WHERE) CAT SCAN(WHEN/WHERE)
		SIEZURES
		HEAD TRAUMA/LOSS OF CONSIOUSNESS
		DIZZINESS/FAINTING
		WEAKNESS/PARALYSIS
		BRAIN TUMOR
		MIGRAINE/CHRONIC HEADACHES (FREQUENCY, EVALS & TREATMENT)
		GENITAL/ URINARY
		ENURESIS/ BEDWETTING
		INCONTINENCE
		PAINFUL/DIFFICULT/FREQUENT URINATION
		KIDNEY DISEASE/BLOOD IN URINE
		FREQUENT URINARY TRACT INFECTIONS
		DISCHARGE
		HISTORY OF SEXUAL ABUSE
		SEXUALLY ACTIVE
		SEXUALLY TRANSMITTED DISEASES
		MUSCULO-SKELETAL
		SCOLIOSIS
		FRACTURES/BROKEN BONES
		BACK PROBLEMS
		JOINT PROBLEMS
		OTHER
		DERMATOLOGY
		RASH
		ACNE/TREATMENT
		PSORIASIS
		CHILDHOOD/INFECTIOUS DISEASES
		CHICKEN POX (AGE)
		MEASLES (AGE)
		RUBELLA (AGE)
		OTHER

OTHER HEALTH PROBLEMS (PAST OR PRESENT)

_____

_____

_____

_____

PREVIOUS HOSPITALIZATIONS

_____

_____

_____

SURGERIES

_____

_____

MEDICAL HISTORY / FILE LOCATION

DOCTOR_____TOWN_____

HOSPITAL_____TOWN_____

PSYCHIATRIC/PSYCHOLOGY_____TOWN_____

REMINDER...A COPY OF THE CHILD'S IMMUNIZATION RECORD MUST BE MAILED TO WOODWARD ACADEMY IF NOT BROUGHT IN AT ADMISSIONYOU MAY OBTAIN THIS INFORMATION FROM YOU CHILD'S SCHOOL OR PEDIATRICIAN IF YOU DON'T HAVE IT AT HOME.

INFORMATION PROVIDED BY

NAME_____

RELATIONSHIP_____DATE_____

REVIEWED BY NURSE_____

DATE / TIME_____

STUDENT'S NAME: _____

WOODWARD ACADEMY
UNAPPROVED TELEPHONE / MAIL/ / VISIT LIST

PLACING WORKER AND/OR PARENTS: Please complete the following information for our records:

I hereby acknowledge that I have read, understand and agree to the conditions contained in the Woodward Academy Mail/Telephone/Visitation Policy. I understand that contact with a child's immediate family cannot be disallowed without a court order per licensing regulation 114.13(3)a.

The following individuals are UNAPPROVED for contact:

Date Initiated:	**Reason for no or limited contact:**	
Name of Individual:		
Relationship to the student:	**Unapproved For:** ☐ telephone contact ☐ mail contact ☐ on-campus visits ☐ off-campus visits	
Date referring worker was notified:	**Plan to regain contact:**	
Date parents were notified:		
Court Order: YES NO	**Student's Initial:**	**Date Discontinued:**

Date Initiated:	**Reason for no or limited contact:**	
Name of Individual:		
Relationship to the student:	**Unapproved For:** ☐ telephone contact ☐ mail contact ☐ on-campus visits ☐ off-campus visits	
Date referring worker was notified:	**Plan to regain contact:**	
Date parents were notified:		
Court Order: YES NO	**Student's Initial:**	**Date Discontinued:**

STUDENT'S NAME: _____

Date Initiated:	**Reason for no or limited contact:**
Name of Individual:	
Relationship to the student:	**Unapproved For:** ☐ telephone contact ☐ mail contact ☐ on-campus visits ☐ off-campus visits
Date referring worker was notified:	**Plan to regain contact:**
Date parents were notified:	
Court Order: YES NO	**Student's Initial:** / **Date Discontinued:**

SUBSEQUENT REVIEWS:

Date	Initial	Date	Initial	Date	Initial	Date	Initial

_____ _____

Parent/Guardian Date Placing Worker Date

_____

Student Date

All parties have read and agree with the above listed names

Woodward Academy
1251 334th Street
Woodward, Iowa 50276

Woodward Academy is a residential placement managed and operated by Sequel Youth Services and located at the aforementioned address.

Your child/ward has been accepted into our program. The following information is required in order to provide quality services to your child.

General Information:
Student's Legal Name:_____
Dare of Birth:_____ (Please attach a certified copy of the Birth Certificate)
Social Security Number:_____ (Please attach a copy of the card)

Medical Information:
Medical Conditions, medications or allergies that your child/ward may have:
_____

Medical Insurance/Medicaid Information (check those that apply)

☐ **Private Insurance Plan**
If you or your child possess a private health plan, please complete the Medical Care Information below. ***Also, please send a copy of the front and back of the insurance plan card.***

Policy Holder's Name as it appears on the card:_____
Policy Holder's Date of Birth:_____ Relationship to Student:_____
Policy Holder's ID Number:_____ Group Number:_____
Employer's Name and Address:_____
_____
Name and address of Insurance Company:_____
_____
Policy Covers (check those that apply): ☐ Major Medical ☐ Eye Care ☐ Dental ☐ Prescriptions

☐ **Medicaid (Title 19)**
Title 19 Number:_____
Please send a copy of the most recent Title 19 card you have received. If you receive cards in the future, please forward them to us to ensure the utmost quality of care for your child/ward.
I state that the information given is correct to the best of my knowledge. I also give authorization for payment of hospital benefits directly to the hospital and medical benefits directly to the physician(s). I agree to pay any and all hospital, medical, pharmacy, co-pays and deductibles that

exceed or that are not covered by my medical insurance, Title XIX or State Medical Coverage that are a result of care for my child/ward.

Legal Guardian/Parent initial here_____

In order to allow your child/ward the maximum opportunities and services provided while placed at Woodward Academy, we request your permission for the following:

☐ **Consent to Treatment**

I apply and consent to such psychiatric, psychological, mental health, medical, medical screening and follow-up, diagnostic, immunizations, substance abuse, emergency and hospital treatment including anesthesia, as professionals contracting with Woodward Academy may prescribe. I am aware the practice of medicine and mental health is not an exact science and I acknowledge that no guarantees have been made to me regarding the results of treatment or examinations.

Legal Guardian/Parent Initials here_____ **Student Initials here**_____

☐ **Reciprocal Authority for Release and/or Exchange of Information**

I authorize the release and/or exchange of all necessary information (written or verbal) to and among the service providers listed below, as well as, other providers contracting services for the purpose of providing educational, residential and/or temporary shelter care to my child/ward. All information shared/requested shall be on a "need to know" basis and comply with the Privacy Practices (HIPAA) of Woodward Academy.

Providers: Woodward Academy, Department of Human Services (to include any past child abuse reports), Juvenile Court Services or other child placing agency(s), Youth Attorney, Guardian ad Litem, University of Iowa Family Care, Dallas County Hospital, Dr. Terry Augspurger (consulting psychiatrist), Dr. Joel Wright & Dr. Greg Steffen (dental), Dr. Todd Miller (podiatry), Eye Care Associates, Medicap Pharmacy, Michael Gentz (audiology), Local Area Education Agency and the child's resident school.

Legal Guardian/Parent Initials here_____ **Student Initials here**_____

☐ **Consent to Interview**

Note: As an integral part of Woodward Academy, we encourage involvement in the various academic, athletic and job opportunities offered on campus. At times, local and national media request pictures and/or interviews with our students as recognition of an individual or group accomplishment.

Consent: I authorize Woodward Academy to allow the name and/or photograph of my child/ward to be made public either through Woodward Academy circulations, media or other publication(s).

Legal Guardian/Parent Initials here_____ **Student Initials here**_____

☐ **Consent to Work**

Note: As previously stated, students at Woodward Academy may have the opportunity to engage in job opportunities on and/or off campus. This allows students to work toward completion of restitution and/or

community service obligations or begin saving for their future.
Consent: I authorize Woodward Academy to allow my child/ward to participate in employment opportunities either on or off campus while placed at Woodward Academy.

Legal Guardian/Parent Initials here_____ Student Initials here_____

☐ **Consent to Travel and Participate**
Note: This consent allows your child/ward to engage in athletic, educational and recreational activities as a representative of Woodward Academy to accompany Woodward Academy staff and students on off campus events or trips. Due to our geographical location, many of these trips may be outside the state of Iowa to include, but not limited to, Nebraska and Missouri.
Consent: I understand that all activities involve the risk of injury. I consent/request my child/ward be given the opportunity of participating in interscholastic sports, off campus activities, field trips, etc.

Legal Guardian/Parent Initials here_____ Student Initials here_____

☐ **Notice of Privacy Practices Acknowledgement**
Note: "HIPPA", State and Governmental privacy guidelines were implemented to protect you and your child/ward's health information. Woodward Academy has developed a privacy plan in order to comply with these guidelines. Enclosed with the aforementioned consent(s)/medical information request please find a copy of this plan. This copy is yours to keep for your review. By initialing/signing below you acknowledge receipt of this privacy plan.

Legal Guardian/Parent Initials here_____ Student Initials here_____

I have read and understand the information above. I understand that my initials are the same as my signature in this document. I understand I can terminate consent to any or all by way of written form to Woodward Academy.

Legal Guardian/Parent Signature:_____ Date:_____

Legal Guardian/Parent Printed Name:_____

Student's Signature:_____ Date:_____

Student's Printed Name:_____

WOODWARD ACADEMY MEDICAL/DENTAL INSURANCE INFORMATION

Student Information: Current status

Name:	SS#:	DOB:
Address:	City:	State/Zip:
Home Phone:	Program:	ID#:

Notify in case of emergency

Name:	Address:	Phone#:

Guarantor Information(Parent/Guardian responsible for bills)

Name:	SS#:	Relationship to student:
Address:	City:	State/Zip:
Employer:	Home Phone:	Work Phone:
Employer Address:	City:	State/Zip:

Is student covered by any private insurance? yes no HMO_____ PPO_____

Name of Current Physician & Phone #

Insurance Information(Primary)Check services provided: __medical__dental__vision__prescription__mental health

Name of Insurance Company:	
Person who carries policy(subscriber):	
Subscriber's DOB: SS#	
Relationship to student:	Policy #:
Address of Insurance Company:	Phone #:
City/State:	Zip:

Secondary Insurance Company

Company:	Subscriber:	Policy #:
Address:	City:	State/Zip:

Dental:

Company:	Subscriber:	Policy #:
Address:	City:	State/Zip:

DOES YOUR INSURANCE REQUIRE PREAPPROVAL BEFORE HOSPITALIZATION OR TREATMENT? PHONE NUMBER FOR APPROVAL PROCESS:_____

CONSENT TO MEDICAL/DENTAL CARE: I voluntarily consent to medical/dental care which is determined to be necessary or beneficial in the professional judgment of my physician. This includes routine diagnostic procedures and medical/dental treatment by authorized agents and employees of the facility, and by their staff. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE EFFECT OF SUCH EXAMINATIONS OR TREATMENT OF MY CONDITION.

FINANCIAL AGREEMENT: I, the undersigned, as the guarantor, agree that in consideration for the services rendered do hereby assign payment directly to the medical/dental/optical/pharmacy/laboratory providers, see attached sheet, otherwise payable to me, but not to exceed regular and customary charges for said services. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance coverage.

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize and direct the _____, having treated me, to release to government agencies, insurance carriers, who are financially liable for medical/dental payments for services rendered, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also authorize the release of my records related to the care of the student to [redacted] to ensure appropriate care is provided.

SVS

Date _____ Parent/Guardian Signature _____ Relationship _____

jstickel;medden

Parent Consultation

Student's Name_____Date_____
Parent Completing Consultation_____

Please complete this consultation to the best of your knowledge. It is extremely important that Woodward Academy has the input on your family dynamics and your perspective of your son. If you have information you feel will be helpful in understanding and rehabilitating your son that is not included in this consultation, please include that information on the space provided on the back of this form. Thank you.

Describe the makeup of your household (include names, ages and relationship to your son) ____

_____

_____

_____

Would you describe your home environment as structured or unstructured? (include daily expectations you have for your son, household rules, etc.) _____

_____

_____

_____

_____

How do you reward your son for positive behavior?_____

_____

_____

How do you discipline your son for negative behavior?_____

_____

_____

How much time are you at home? (include what hours of the day)_____

_____

_____

How much time do you spend with your son and how is this time spent?_____

_____

_____

_____

What do you see as your son's strengths?_____

_____

_____

Positive interests?_____

_____

_____

What do you see as your son's weaknesses?_____

Negative interests?_____

Do you see your son as a leader or a follower? Positive or negative?_____

What goals do you have for your son while he is at Woodward Academy?_____

Long term goals for your son?_____

What is the plan for your son's living arrangements upon discharge from Woodward Academy?

List significant people in your son's life that may be positive role models or influences (name and relationship)_____

Additional comments_____

Parental Consultation Substance Abuse

Are you aware of any substance use by your son?

Are you concerned that your son may be abusing drugs or alcohol? If so, why?

If so, what do you want to see your son learn about or change concerning his drug and/or alcohol use?

Are you aware of any resources that are available within the community that could help your son stay drug and alcohol free?

What are your goals for your son dealing with his substance abuse?

Is there a history of drug or alcohol abuse within your family?

Additional comments

I;common;parentco

Woodward Academy

RELEASE OF INFORMATION CONSENT

This Consent Authorizes _____
Name of facility or individual to release information

_____
Address of facility or individual to release information

To Release Information To _____
Name of facility or individual to receive information

_____
Address of facility or individual to receive information

Regarding: Patient Name _____ Date of Birth _____

Date of Treatment: From _____ To _____

For the Purpose of: _____ Comprehensive Evaluation _____ Education Planning
_____ Continued Care _____ Other: _____

Specific Information to be Disclosed:

_____ Face Sheet	_____ History and Physical	_____ Discharge Summary
_____ Medical Consultation	_____ Psychiatric Evaluation	_____ Lab Reports
_____ Psychological Testing	_____ MRI and CAT Reports	_____ Educational Evaluation
_____ Drug and Alcohol Records	_____ EEG and EKG Reports	_____ Grades and Transcripts
_____ Social Assessment	_____ Substance Abuse Assessment	_____ Treatment Plan
_____ Progress Notes	_____ Other	

_____

This authorization for release of information is valid from: _____ to: _____
Month/Day/Year Month/Day/Year

If a date is not specified, this consent shall expire on year from the signature date. This consent to release information may be revoked at any time, except where actions have already been taken on the basis of this consent.

I have been informed of the specific types of information that have been requested and give my consent freely and voluntarily. I understand that treatment services are not contingent upon whether this information is released or not. A photocopy of this authorization is considered acceptable in lieu of the original. I understand information to be released may include confidential HIV-related information, confidential communicable disease related information, and alcohol or drug abuse related information.

_____ _____
Parent/guardian Signature Date Witness Signature Date

_____ _____
Patient Signature Date Releasing Staff Date

NOTICE TO PERSONS RECIEVEING THE ABOVE INFORMATION
The above information cannot be disclosed to other agencies or personas. Federal regulations state "This information has been disclosed to you from records whose confidentiality is protected by Federal Law and the 1996 "HIPAA" law. Federal Regulations (42 CFR part 2, June 1987) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation A general authorization for release of medical information is NOT sufficient for this purpose."

SCHOOL DISTRICT WORKSHEET

STUDENT NAME_____

DOB_____ SS#_____

SCHOOL INFORMATION

Current Grade_____

Name and address of the school district where student resides:

_____

_____

_____

Telephone _____

CONTACT PERSONS

Director of Special Education_____

Principal_____

School Counselor_____

Teacher_____

SCHOOL HISTORY

Was the student ever in Special Education?_____

If so, when?_____

If so, what?_____

Learning Problems? Attention____ Reading____ Spelling____

Speech____ Behavior____

Does the school district know of placement?_____

Parent/Guardian Signature_____ Date_____

I;common;schdisws

WOODWARD ACADEMY
VOLUNTEER REGISTRATION

THE INFORMATION ON THIS FORM HELPS US TO FIND THE MOST APPROPRIATE VOLUNTEER SERVICE FOR YOU. PLEASE FILL OUT THE FOLLOWING INFORMATION.

PERSONAL INFORMATION:

_____ _____
(Student's Name) (Date)

_____ _____
(P.O. Box/Street Address) (Telephone Number)

_____ _____
(City, State/Zip Code) (Date of Birth)

DO YOU HAVE ANY PHYSICAL LIMITATION? YES OR NO
(anything wrong with you so you cannot participate)

IF YES, PLEASE DESCRIBE:_____
_____
_____

CASE OF EMERGENCY, WHOM MAY WE CALL?
_____
(Name) (Phone Number)

EMPLOYMENT HISTORY:
Brief Employment History:

DATE EMPLOYED	JOB DUTIES	BUSINESS
_____	_____	_____
_____	_____	_____

VOLUNTEER HISTORY:
Brief description of previous volunteer or community involvement (including community service):_____
_____
_____
_____

Brief Description of your interests and skills and career ambitions:_____
_____
_____
_____

Department of Human Services will consider this application without regard to race, color, national origin, sex, religion, age, creed, physical or mental disability, or political belief.

LIABILITY:

Volunteers are entitled to liability protection on the same basis as state employees under Iowa Code Chapter 25A. This protection is not, in all instances, complete. If you should have any questions, please contact either the state volunteer program director or the attorney general's office.

CONFIDENTIALITY:

All records and information to which you will have access as a Department of Human Services volunteer are confidential and are protected by law. Your signature on this form will certify that the confidentiality of this information has been explained to you. Your signature signifies an agreement between you and the department that you promise not to discuss any confidential information including, but not limited to, any description of situations as well as names of patients, clients or residents with whom you work.

Your signature means that you promise to share pertinent and confidential information only within the context of a work situation and only with persons working with the Department of Human Services.

Breech of this confidence is a violation of the criminal law and reason for immediate termination of your services with the Department of Human Services. It may lead both to a criminal prosecution against you and to a civil damage action in which you would not have any protection of Chapter 25A.

_____

(Name of volunteer/student) (Date)

_____

(Signature of parent/staff) (Date)

i;common;forms;volunt

NEW STUDENT BILLING INFORMATION

Name: _____

Date of Birth: _____ *SSN* _____

GUARDIAN: _____

_____

_____

_____

Phone Number: (H) _____ *(W)* _____

Date of Admission: _____

State: _____ *T19 number:* _____

Private Health Insurance: _____

Policy Holder: _____ *DOB:* _____

Policy Number: _____ *Group #:* _____

SSI: _____ *Rx Coverage:* _____

Rx Phone #: _____ *Rx Bin#* _____

Insurance Address: _____

_____

_____

_____

Insurance Phone #: _____