PROVO CANYON SCHOOL
— ADMISSIONS PAPERWORK —

PATIENT INFORMATION: **DATE OF ADMISSION:** _____

Patient Name: _____ Age: _____ Sex: _____

Mailing Address: _____ City: _____ ST: ____ Zip: _____

Resident Address: _____ City: _____ ST: ____ Zip: _____

Date of Birth: _____ Place of Birth: _____ Citizenship: _____

If adopted, when? _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Social Security Number: _____

Please Provide All Insurance Info Below:

PRIMARY INSURANCE INFORMATION:

Name: _____ Policy No: _____ Group No: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Name of Insured: _____ Insured SS#: _____

SECONDARY INSURANCE INFORMATION:

Name: _____ Policy No: _ _____ Group No: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Name of Insured: _____ Insured SS#: _____

DENTAL INSURANCE INFORMATION:

Name: _____ Policy No: _____ Group No: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Name of Insured: _____ Insured SS#: _____

VISION INSURANCE INFORMATION:

Name: _____ Policy No: _ _____ Group No: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Name of Insured: _____ Insured SS#: _____

PRESCRIPTION COVERAGE:

Name: _____ Policy No: _____ Group No: _____ BIN #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Name of Insured: _____ Insured SS#: _____

SOURCE OF REFERRAL TO PROVO CANYON SCHOOL:

Friend: ____ Relative: ____ Professional: ____ Agency: ____ Advertisement: ____ Other: _____

Name: _____ Occupation: _____

FATHER INFORMATION:

Name: _____ Home Phone: _____ Mobile Phone: _____
Mailing Address: _____ City: _____ ST: ____ Zip: _____

Resident Address: _____ City: _____ ST: ____ Zip: _____

Employer Name: _____Address: _____ City: _____ ST: ____ Zip: _____

Social Security #: _____ Date of Birth: _____ Email: _____

MOTHER INFORMATION:

Name: _____ Home Phone: _____ Mobile Phone: _____
Mailing Address: _____ City: _____ ST: ____ Zip: _____

Resident Address: _____ City: _____ ST: ____ Zip: _____

Employer Name: _____Address: _____ City: _____ ST: ____ Zip: _____

Social Security #: _____ Date of Birth: _____ Email: _____

STEP FATHER INFORMATION:

Name: _____ Home Phone: _____ Mobile Phone: _____
Mailing Address: _____ City: _____ ST: ____ Zip: _____

Resident Address: _____ City: _____ ST: ____ Zip: _____

Employer Name: _____Address: _____ City: _____ ST: ____ Zip: _____

Social Security #: _____ Date of Birth: _____ Email: _____

STEP MOTHER INFORMATION:

Name: _____ Home Phone: _____ Mobile Phone: _____
Mailing Address: _____ City: _____ ST: ____ Zip: _____

Resident Address: _____ City: _____ ST: ____ Zip: _____

Employer Name: _____Address: _____ City: _____ ST: ____ Zip: _____

Social Security #: _____ Date of Birth: _____ Email: _____

LEGAL GUARDIAN INFORMATION:

Name: _____ Home Phone: _____ Mobile Phone: _____
Mailing Address: _____ City: _____ ST: ____ Zip: _____

Resident Address: _____ City: _____ ST: ____ Zip: _____

Employer Name: _____Address: _____ City: _____ ST: ____ Zip: _____

Social Security #: _____ Date of Birth: _____ Email: _____

EMERGENCY CONTACT:

Name: _____ Home Phone: _____ Mobile Phone: _____

Mailing Address: _____ City: _____ ST: ____ Zip: _____

Relationship to Patient: _____

COMMUNICATION PREFERENCE: I understand I may be contacted by Provo Canyon School through various means indicated on this application. I grant Provo Canyon School the permission to contact me through means indicated. However, the communication preference I would prefer is:
Email: _____ Home Phone: _____ Mobile Phone: _____ Fax: _____
DIGITAL COMMUNICATION AUTHORIZATION: _____ by initialing here, you are authorizing confidential communication by email to the above email address.

PATIENT LEGAL STATUS

Patient Name: _____ Sex: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

_____ _____

Family Status: ☐ Intact ☐ Divorced ☐ Single ☐ Separated

Legal Custody: ☐ Parents ☐ Mother ☐ Father ☐ Court ☐ Guardian

Physical Custody: ☐ Parents ☐ Mother ☐ Father ☐ Court ☐ Guardian

Other (Please Specify): _____

Note: If custody is other than (1) both parents (married or intact relationship), or (2) single parent family, a copy of the divorce decree and/or all documentation pertaining to custody and visitation MUST be sent to us. We also request official court documentation be sent to us as well.

I affirm that as ☐ Parent, ☐ Guardian, ☐ Officer of the Court, I have custody of the above-named minor child and to the best of my knowledge supplied the most recent documentation regarding custody and visitation of my child, and that I do here by request admission of said child to Provo Canyon School.

Parent/Guardian/Officer of the Court (print name): _____

Parent/Guardian/Officer of the Court (signature): _____

Witness (print name): _____ Witness (signature): _____

COURT PLACEMENTS ONLY

I further grant permission for communication with parents or guardians as follows:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

CONSENT FOR TREATMENT AND TERMS OF PARTICIPATION

By signing this form, the undersigned hereby grants to Provo Canyon School ("School") full consent, authorization, and permission to provide such care, treatment, and evaluation as specified in this form, including emergency treatment as the School considers necessary and appropriate, to:

Minor's Full Legal Name: _____ Date of Birth: _____

Consent to and authorize medical and psychiatric treatment of the Minor, including medications as may be prescribed by the Minor's treating practitioner, as deemed medically necessary or advisable for the well-being of the Minor and to provide or secure urgent/emergency treatment as the School considers necessary and appropriate. This consent of authorization includes, but is not limited to, pregnancy testing, drug screening, tuberculosis testing, use of over-the- counter medications, complete physical examination including a genital examination, inpatient or outpatient hospital care, psychological screening, searches (body, clothing, room, belongings, and mail) and to provide any procedure that may be deemed medically necessary for the well-being of the Minor.

Consent to and authorize the use of seclusion or restraint as may be necessary due to the severity of symptoms, if behaviors warrant, or to protect the Minor from harming self, others or School property. If such seclusion or restraint becomes necessary during the Minor's enrollment, then the undersigned further agree to indemnify the School, its employees or agents from any loss due to injury that may occur as a result of such seclusion or restraint. Seclusion or restraint will be utilized only after less restrictive measures have failed or were not indicated.

Consent to and authorize the school to release confidential medical and mental health information to those agents whose direct responsibility is to determine medical necessity, payments of claims, and/or continuation of care and understand that such records may contain diagnosis, treatment and prognosis with respect to physical and mental conditions, to include records of drug and alcohol abuse, and/or treatment.

Consent to and authorize the School to conduct academic and psychological evaluations as deemed necessary or advisable to assess the Minor's educational and psychological functioning.
Consent to and authorize the Minor to participate in all programs and activities of the School, including but not limited to educational therapeutic programs, neuro-feedback, bio-feedback, spiritually based activities, work projects, animal assisted activities, training programs, aquatic activities, skate boarding, and various forms of recreation and competitive athletics. The undersigned further consent to and authorize the Minor to attend Orem Recreation Center, and have their name released to them, for the purpose of recreation. I understand that Provo Canyon School provides services to students that have turned 18 while in treatment to complete education or treatment goals and understand that my child may have contact with them.

Release, indemnify, and hold harmless the School, its employees, agents, and Medical Staff from all liability, claims, costs, and losses incurred as a result of any act of the Minor while participating in field trips, activities, and leaves. The undersigned further release, indemnify, and hold harmless the School from loss or damage of a personal item brought by Minor into the School.

Consent to and authorize the taking of photographs and videotaping for internal identification, security, and therapeutic purposes. However, with the specific exception of identification of Minors absent without leave, no likeness shall be disclosed externally without specific written authorization.

Consent to and authorize the use of video conferencing technology that may be used to facilitate court appointments, semi-annual reviews, therapeutic sessions or other student enrichment team meetings through a secured video conferencing network.

Understand and acknowledge that physicians and other professionals treating Minors may be independent contractors not employed by School and will be exercising independent professional judgment to which School is not liable.

I represent and warrant that all weapons, lethal medications, and other means of self-harm have been removed and/or secured from the home prior to the Minor's return.

Parent or Guardian (Print Name): _____

Parent or Guardian (Signature): _____ Date: _____

Witness (Signature): _____ Date: _____

ACKNOWLEDGEMENT OF THE PERSONAL RIGHTS OF MY CHILD

1. To receive individual, group, family therapy, or other forms of treatment that are determined to be needed, impartially, and without regard to race, color, sex, nationality, religion, handicap, or the source/s of financial support.
2. To receive such therapy and treatment in a caring and humane manner.
3. To have my cultural, psychosocial, spiritual and personal values, beliefs, and preferences respected.
4. To be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation.
5. To be recognized as an individual possessing inherent value and to have that value respected in the provision of all care and treatment.
6. To be provided an environment that preserves dignity and contributes to a positive self-image.
7. To expect reasonable safety insofar as the School practices and environment are concerned.
8. To participate in planning and implementing my individual treatment plan, including assessing and measuring my personal progress. I am expected to ask questions, express concerns about my treatment plan, or my ability to complete what is expected of me. The School will make reasonable efforts to adapt the plan of care to my specific needs and limitations.
9. To communicate by telephone or in writing with family, attorney, physician, clergyman, and counselor or case manager except when contraindicated by the licensed clinical professional. In the case where there are clinical restrictions regarding mail or use of the telephone, my therapist will explain those to me, and help me resolve the restrictions when it is in my best interest. If I desire a private telephone call I can ask my therapist to make the necessary arrangements.
10. To contact protective legal and advocacy services except when clinically contraindicated.
11. To receive all mail, and to have telephone phone calls, unless it is decided by parents and clinical staff not to be in my best interest. In the case where there are clinical restrictions regarding mail or use of the telephone, my therapist will explain those to me, and help me resolve the restrictions when it is in my best interest. If I desire a private telephone call I can ask my therapist to make the necessary arrangements.
12. To have my personal privacy and confidentiality assured and protected, within the constraints of my individual treatment plan.
13. To participate in a full-time academic program, unless this is contraindicated by my individual treatment plan or other clinical considerations.
14. To participate in facility provided non-denominational religious/spiritual services, unless clinically contraindicated.
15. To receive medical care and treatment for pain, illness, or injury, if needed.
16. To be restituted for personal belongings if maliciously damaged by others. Staff will assist me in completing a restitution form.
17. To complete a written grievance when I feel my rights have been violated, and to have it reviewed by an advocate.

I affirm that as ☐ Parent, ☐ Guardian, ☐ Officer of the Court, I understand the Statement of personal rights for services provided by Provo Canyon School for my child as the legal guardian.

Parent/Guardian/Officer of the Court (print name): _____

Parent/Guardian/Officer of the Court (signature): _____

Witness (print name): _____ Witness (signature): _____

CONSENT TO SEARCH

By signing this form, the undersigned hereby grants to Provo Canyon School ("School") full consent, authorization, and permission to provide such care, treatment, and evaluation as specified in this form and in search policy, including emergency treatment, as the School considers necessary and appropriate, to:

Minor's Full Legal Name: _____ Date of Birth: _____

Consent to and authorize medical and psychiatric treatment of the Minor, including a search of the patient and/or belongings. A search of a patient and/or belongings may be conducted but is not limited to the following occasions: Upon admission to the program, upon returning from a visit/off campus visit/activity/elopement, upon admission to the Stabilization and Assessment unit, in investigating possible stolen property or searching for contraband, illegal drugs, weapons, etc., when there has been a self-harm incident, such as cutting, tattooing, etc., upon leaving for a visit or discharge, etc.

Types of Searches:

External Body Search: A body search is defined as having a patient remove their clothing in a systematic fashion, removing and replacing one article of clothing at a time, as to ensure dignity. A nurse/licensed medical staff will be present for the body search with another staff member of the same gender as the patient.

Clothing Search: A clothing search is defined as a systematic inspection of clothing that does not require the removal of pants, shirts, or under garments. There will be two staff members present during a clothing search, such as a medical professional (e.g. nurse, etc.) or staff member.

Belongings Search: Anytime a patient brings belongings into the facility, the belongings are subject to a thorough search by a staff member. No belongings are to be on the dorm/cottage without having been searched for contraband. Belongings are to be kept in the inventory area until a search has been completed.

Room Searches: A room search may be conducted during routine cleaning or when there is reason to believe that a patient has hidden contraband in their room and that such contraband presents imminent danger to that particular patient or others.

Mail Searches: In the event that a patient is suspected of receiving contraband in the mail, a search of mail may be conducted in the presence of the patient, per policy, to ensure safety.

Visitor Searches: Inspection of items being brought in by visitors will be at the discretion of the staff. Should items be found that are deemed a threat to safety, visitors should be advised to lock the items in their vehicle or in the lobby lockers provided to secure personal items.

Patient Refusal/Contraindications: If a patient refuses a search, he/she shall not be forced. The nurse will contact the physician for an order and the patient will be placed on close proximity observation until a search is possible, or the situation is resolved. The patient's refusal shall be documented and appropriate precautions initiated.

Internal Body Search: Internal or body cavity searches are not performed at Provo Canyon School. If a body cavity search is required, the patient will be sent to the emergency room. The Licensed Independent Practitioner must specify justification for the search in the written order. A detailed report of the justification for the search, all less intrusive methods attempted, method in which search was conducted, all staff present, and results of the search are to be documented. A parent/guardian notification is required.

Parent or Guardian (Print Name):_____

Parent or Guardian (Signature): _____ Date: _____

Witness Signature: _____ Date: _____

Witness Job Title: _____

Consent for Provo Canyon School to exchange information from the records of:

Patient Name: _____ Date of Birth: _____

Provo Canyon School is released from all legal liability that may arise from the release of information authorized. I understand that the records may contain diagnosis, treatment and prognosis with respect to physical or mental conditions, to include records of alcohol and drug abuse, communicable disease, and/or treatment. Purpose of disclosure is to provide support of care and treatment. **A photocopy of this authorization shall be effective as an original.**

	EXCHANGE RECORDS WITH:	INFORMATION TO BE DISCLOSED:	EXPIRATION DATE:	INITIAL TO APPROVE AND SIGN BELOW
*Referral source	Name: Phone: Address: Name: Phone: Address:	Verbal exchange Data Base* Progress Notes Discharge Summary Other _____	60 days After Discharge	***Only initial if names listed** Guardian _____ Witness _____
*Mental Health Professionals	Name: Phone: Address: Name: Phone: Address:	Verbal exchange Data Base* Progress Notes Discharge Summary Other _____	60 days After Discharge	***Only initial if names listed** Guardian _____ Witness _____
*Court Officials	Name: Phone: Address: Name: Phone: Address:	Verbal exchange Data Base* Progress Notes Discharge Summary Other _____	60 days After Discharge	***Only initial if names listed** Guardian _____ Witness _____
*Family Members Or Others	Name: Phone: Address: Name: Phone: Address:	Verbal exchange Progress Notes Other _____	60 days After Discharge	***Only initial if names listed** Guardian _____ Witness _____
* Individual School Teachers, Counselors	Name: Phone: Address: Name: Phone: Address:	Verbal exchange Psych Testing Academic Testing Academic Reports Other _____	6 Months After Discharge	***Only initial if names listed** Guardian _____ Witness _____
*Insurance	THIRD PARTY PAYOR OR AGENTS:	Verbal exchange Base Treatment Reviews Discharge Summary Other _____	Until Settlement of Claim	***Only initial if names listed** Guardian _____ Witness _____

*Data Base includes psychiatric, psychological and psychosocial evaluations, medical history and physical examinations, and master treatment plan. I understand that the records are protected and cannot be disclosed without my permission. Alcohol/drug treatment records are protected by federal regulation 42 CFR, part 2. I also understand that my consent for disclosure is subject to my written revocation. I cannot take exception to actions that have taken that have taken place before I withdrew consent. The consents are limited to the respective times listed above.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Only sign this form if you list any entity or person. If you do list any entity or person, please sign AND initial above.

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION (FORM CDCI)

Patient Name: _____ Date of Birth: _____

I hereby AUTHORIZE and/or REQUEST disclosure of confidential medical and mental health information in accordance with the terms and conditions set forth below. Purpose of disclosure: Continuation of Care

Information to be released to: PROVO CANYON SCHOOL
4501 North University Ave.
Provo, Utah 84604

801-227-2102 (Office Number)
801-227-2009 (fax)

PLEASE LIST PREVIOUS PROVIDERS WITH CONTACT INFORMATION INCLUDING ADDRESSES/PHONE NUMBERS/FAX NUMBERS.

ANY AND ALL RECORDS MAY BE RELEASED, INCLUDING VERBAL CONTACT.

Primary Care Physician: _____
Address: _____
_____
Phone/FAX: _____

Initial to approve: Guardian _____ Witness _____

Psychiatrist: _____
Address: _____
_____
Phone/FAX: _____

Initial to approve: Guardian _____ Witness _____

Other Medical Physician: _____
Address: _____
_____
Phone/FAX: _____

Initial to approve: Guardian _____ Witness _____

Other Medical Physician: _____
Address: _____
_____
Phone/FAX: _____

Initial to approve: Guardian _____ Witness _____

Any information obtained will not be released by the above-named person or organization to any other person or organizations unless I so authorize. IN ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART 2) I hereby also consent to the release of any and all alcohol and/or drug abuse treatment records under the same conditions outlined below. I understand that such information cannot be released without my consent, except under special circumstances.

This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. **If not previously revoked, this consent will terminate one year from the time of discharge**. To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information Privacy Standards), 45 DFS 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder. Once the requested Protected Health Information (PHI) is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient re-discloses it.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Only sign this form if you list any entity or person. If you do list any entity or person, please sign AND initial above.

PERMISSION FOR EDUCATION RECORDS TRANSFER TO PROVO CANYON SCHOOL

Parents, please request a copy be sent if possible prior to admission.

Patient Name: _____ Date of Birth: _____

Please send:
Transcripts/Report Cards
Health/Immunization Records
Current IEP

PLEASE DO NOT SEND THE CUMULATIVE FILE

Information to be released to:	☐ **Provo Campus** Middle School Boys Program High School Boys Program Utah DCFS Program	☐ **Springville Campus** Elementary Boys and Girls Program Middle School Girls Program High School Girls Program
Address:	4501 North University Avenue Provo, Utah 84604	763 North 1650 West Springville, Utah 84663
Phone Number:	801-227-2040	801-704-1399
Fax Number:	801-227-2130	801-491-3911

Previous School: _____

City/State: _____

Telephone: _____

Attendance Dates: _____

Discharge Grade Level: _____

During the last four years, list other school names including placement centers:

_____

_____

_____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ICPC 100A
REV. 8/2001

INSTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

One form per child Please type

SECTION I – IDENTIFYING DATA

Notice is given of intent to place - Name of Child:

Social Security Number:

ICWA Eligible ☐ Yes ☐ No

Sex:

Date of Birth

Title IV-E determination ☐ Yes ☐ No ☐ Pending

Ethnicity: Hispanic Origin: ☐ Yes ☐ No ☐ Unable to determine/unknown

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ White
☐ Native Hawaiian / Other Pacific Islander
☐ Black or African American

Name of Mother:

Name of Father:

Name of Agency or Person Responsible for Planning for Child:

Phone:

Address:

Name of Agency or Person Financially Responsible for Child:

Phone:

Address:

SECTION II – PLACEMENT INFORMATION

Name of Person(s) or facility Child if to be placed with:
Provo Canyon School

Social Security # (optional):

Address:
☐ **4501 N University Avenue, Provo, UT 84604** ☐ **763 North 1650 West, Springville, UT 84663**

Phone:
801-491-3910

Type of Care Requested:
☐ Foster Family Home
☐ Residential Treatment Center
☐ Group Home Care
☐ Child Caring Institution
☐ Institutional Care- Article VI, Adjudicated Delinquent
☐ Parent
☐ Relative (Not Parent)
Relationship:
☐ Other:

☐ ADOPTION
☐ Non IV-E Subsidy
☐ DIV-E Subsidy
To Be Finalized In:
☐ Sending State
☐ Receiving State

Current Legal Status of Child:
☐ Sending Agency Custody/Guardianship
☐ Parent Relative Custody/Guardianship
☐ Court Jurisdiction Only
☐ Protective Supervision
☐ Parental Rights Terminated-Right to Place for Adoption
☐ Unaccompanied Refugee Minor
☐ Other:

SECTION III – SERVICES REQEUSTED

Initial Report Requested (if applicable):
☐ Parent Home Study
☐ Relative Home Study
☐ Adoptive Home Study
☐ Foster Home Study

Supervisory Services Requested:
☐ Request Receiving State to Arrange Supervision
☐ Another Agency Agreed to Supervise
☐ Sending Agency to Supervise

Supervisory Reports Requested:
☐ Quarterly
☐ Semi-Annually
☐ Upon Request
☐ Other:

Name and Address of Supervising Agency in Receiving State:

Enclosed: ☐ Child's Social History ☐ Court Order ☐ Financial/Medical Plan ☐ Other Enclosures
☐ Home Study of Placement Resource ☐ ICWA Enclosure ☐ IV-E Eligibility Documentation

Signature of Sending Agency or Person(**Legal Guardian's/Parents Sign Here**):
X

Date:

Signature of Sending State Compact Administrator, Deputy or Alternate:

Date:

SECTION IV ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) OF ICPC

☐ Placement may be made ☐ Placement shall not be made

REMARKS

Signature of Receiving State Compact Administrator, Deputy or Alternate:

Date:

MANUAL PRIVACY PRACTICES PROCEDURE – BH

Receipt of Notice of Privacy Practices

Version 10403

- ☐ Over 18 years of age
- ☐ Under 18 years of age
- ☐ Emancipated minor child
- ☐ Over 18 but still dependent

An electronic version of our Privacy Practices can be found at: www.provocanyon.com/includes/privacy.pdf

ACKNOWLEDGEMENT
I acknowledge that I have received Provo Canyon School's Notice of Privacy Practices.

Patient Name: _____

Parent/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Witness Signature: _____

Witness Job Title: _____ Date: _____

Patient has requested no exceptions to the use or disclosure of PHI at this time.

Date HIM STAFF entered receipt on chart: _____ HIM Staff Initials: _____

Provo Canyon School Parent Manual

Receipt of Parent Manual

ACKNOWLEDGEMENT

I acknowledge that I have received either an electronic or a physical copy of Provo Canyon School's Parent Manual.

**If you have not received a copy, please reach out to the admissions department at: 1-800-848-9819 and they will send one immediately.*

Parent/Guardian Signature: _____

Relationship to Patient: _____

Witness Signature: _____

Witness Job Title: _____

REQUEST FOR INFORMATION/ASSISTANCE IN LOCATING RUNAWAYS

Patient Name: _____ Patient Number: _____

Date of Birth: _____ Birth Place: _____ Sex: _____

Mother's Maiden Name: _____

Height: _____ Weight: _____ Hair: _____Eyes:_____

Patient Race: _____

Birthmarks/Scars/Tattoos: _____

NAME AND ADDRESS OF PARENT/GUARDIAN:

Name: _____

Home Address: _____

Home Phone: _____ Mobile Phone: _____

Business Address: _____

Business Phone: _____

How long had you lived at the above address? _____

List schools where the patient may have friends (attended prior to PCS):

_____

_____

_____

_____

Are there friends or relatives in Utah or surrounding states that the patient would contact? (Please list names, address and phone numbers if known):

_____

_____

_____

_____

Please list previous home address(s) where the patient may have friends:

_____

_____

_____

_____

Please list possible destinations or people your child might contact (include names, addresses, phone numbers, if known).

Possible Destinations:

_____
_____
_____
_____
_____

Possible Contacts:

_____
_____
_____
_____
_____

If your child has been involved in a runaway before entering PCS, please answer the following questions.

How many times has the patient run away? _____

Destinations? _____

Alone? _____ With whom? _____

How long was the patient gone? _____

How were their needs met? _____ Stealing? _____ Panhandling? _____

Other: _____

Transportation: _____

Hitch-hike? _____ Stolen Vehicle: _____ Bus? _____

Walking? _____ Other: _____

Explain circumstances of the patients return home:

_____
_____
_____
_____
_____
_____

Other Pertinent Information:

_____
_____
_____
_____
_____
_____

APPROVED COMMUNICATION REQUIREMENTS (MAIL, TELEPHONE CALL AND VISITS)

Patient Name: _____ Date of Birth: _____

Dear Parents,

In this form, please indicate a list of people (and their addresses if known) who are approved by you to contact your child via mail, telephone calls and/or visits.

PLEASE NOTE: Legal rights of visitation of a parent cannot be restricted by the other parent unless accompanied by a legal court order.

CORRESPONDENCE/VISIT/TELEPHONE APPROVED LIST

I hereby **APPROVE** correspondence, visits, and/or telephone contact from the following persons with my child.

Name	Address	Relationship to Patient	Approx. Age	(Please Check)		
				Letters	Visits	Phone Calls

MEDICAL/DENTAL HISTORY

Patient Name: _____ Age: _____

Complete every question on both forms.	YES	NO	If "YES", refer to items by number and explain when the problem occurred and give details of present condition, including current medication.
1. Ear pain or any problem with hearing?			
2. Eye discomfort or difficulty?			
3. Frequent headaches?			
4. Dizziness or fainting spells?			
5. Hay fever or nasal problems?			
6. Hives or skin allergies?			
7. Skin sores or rashes?			
8. Warts or sores on feet?			
9. A lump, mole, or swelling?			
10. Coughing?			
11. Chest pain or shortness of breath?			
12. Spitting or coughing up blood?			
13. Sweating at night?			
14. Stomachaches, burning, or indigestion?			
15. Urinary burning, frequent urination or dark urine?			
16. Difficulty in starting urine or dribbling?			
17. Enuresis (bed-wetting)?			
18. Pain in back, neck, joints?			
19. Difficulty walking, running, or lifting things?			
20. A rupture or hernia?			
21. Unexplained weight loss or weight gain?			
22. Pain or bleeding when having bowel movements?			
23. Diarrhea or unusual bowel movements?			
24. Any illness or injury not already noted?			
FEMALES ONLY			
25. Vaginal discharge?			
26. Painful menstruation or irregular periods?			
27. Spotting between periods?			
28. Flowing longer than 8 days?			
29. Date of last menstrual period?			
HAS CHILD EVER HAD:			
30. Sexually transmitted infections?			
31. A knee or ankle injury?			
32. Broken bones and/or deformities?			
33. Arthritis or swollen, painful joints?			
34. Birthmarks and/or tattoos?			
35. Glasses and/or contact lenses?			
36. Any orthopedic appliance (back brace, orthotics)?			
37. Orthodontics (dental braces)?			
38. Date of last orthodontic visit?			
39. A back injury or deformity?			
40. An ulcer?			
41. Surgery or hospitalization?			
42. Any other acute or chronic health problems?			
HAS CHILD OR IMMEDIATE FAMILY MEMBER HAD: Please explain			
43. Tumor, growth, cyst, or cancer?			
44. Heart disease or heart murmur?			
45. Diabetes or sugar in the urine?			
46. High blood pressure?			
47. Asthma or wheezing?			
48. Spitting or coughing up blood?			
49. Seizures, convulsions, or epilepsy?			
50. A goiter or thyroid disease?			

MEDICATION HISTORY

	YES	NO	DETAILS
1. Is your child currently on any prescribed medication? If yes, list below.			
2. Has your child previously been on prescribed medication? If yes, list below			
3. Does your child have any allergies to foods, drugs, or other substances?			
4. Has your daughter been on birth control pills? If so, which medication/ for how long?			

CURRENT MEDICATIONS
(If more room is needed, please attach additional pages)

APPROXIMATE DATE MEDICATION STARTED	MEDICATION NAME	STRENGTH (DOSAGE)	HOW OFTEN MEDICATION IS TAKEN	COMMENTS (Is medication beneficial, are there side effects, etc.)

HISTORY OF MEDICATIONS USED

APPROXIMATE DATE MEDICATION STARTED	MEDICATION NAME	STRENGTH (DOSAGE)	HOW OFTEN MEDICATION IS TAKEN	BENEFICIAL	NOT BENEFICIAL

DENTAL CONSENT

Patient Name: _____

Date of Last Exam: _____

While my child is attending Provo Canyon School, I authorize him/her to see the dentist for a dental examination, cleaning, fluoride, and bitewing x-rays. I know that if any further works such as fillings, sealants, etc. are recommended that Provo Canyon School will contact me by phone or in writing for permission. I also understand that my child will be sent every six months, unless specified otherwise.

☐ I hereby give permission for my child to receive dental care as indicated above.

Parent/Guardian: _____ Date: _____

☐ I hereby DENY permission for my child while at Provo Canyon School to be seen by the dentist for a dental examination/cleaning at this time. I realize that I can request this service to be done at a later date.

Parent/Guardian: _____ Date: _____

INSURANCE INFORMATION

_____

_____

_____

_____

_____

If you do not carry dental insurance, you may need to pre-pay at the time of service.

Patient Number: _____ Patient Name: _____

UTAH SCHOOL IMMUNIZATION

This record is part of the student's permanent school record (cumulative folder) as defined in Section 53A-1, 1-304 of the Utah Statutory Code and shall transfer with the student's school record to any new school. The Utah Department of Health and local health departments shall have access to this record. This immunization record may be entered into the Utah Statewide Immunization Information System (USIIS). For more information about USIIS, please visit the USIIS website at www.usiis.org or see the Family Educational Rights and Privacy Act (FERPA) directory.

INSRUCTIONS: This form must be completed for enrollment in schools and early childhood programs (i.e. a nursery or preschool, licensed day care center, child care facility, family home care, or Head Start Program.) See reverse side for instructions on claiming exemptions for medical, religious, or personal reasons.

Student Name: _____ Gender: ☐ Male ☐ Female Date of Birth: _____

Parent/Guardian: _____ Signature of Parent/Guardian: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone: _____

Does child have health insurance? ☐ YES ☐ NO Name of Insurance: _____

If no health insurance, would you like to be contacted about health coverage for children? ☐ YES ☐ NO

VACCINE	Record the month, day & year vaccine was given				
	1st	2nd	3rd	4th	5th
DTP, DTaP, DT, Td (D-Diphtheria, T-Tetanus, P-Pertussis aP-acellular Pertussis)					
Haemophilus Influenzae b (Hib)					
Polio (IPV or OPV)					
Measles, Mumps, and Rubella (MMR)* 1st dose must be received on or after the 1st birthday			*** If vaccine is given in the completed form (MMR), enter the complete date in the appropriate MMR box.** **** If vaccine is given as a single antigen, enter the date(s) in the appropriate boxes.**		
Measles (Rubeola, 10 day, red measles)**					
Mumps**					
Rubella (German measles, 3 day measles)					
Hepatitis B (HBV)					
Varicella (Chickenpox)			If a student has had the chickenpox disease, parent must sign, to the right.		
Hepatitis A 1st dose must be received on or after the 2nd birthday					

SCHOOL AND EARLY CHILDHOOS PROGRAM USE ONLY:

1. Date of Unconditional Admission: _____
   ALL REQUIREMENTS MET
2. Date of Conditional Admission: _____
3. Exemption was granted for:
   ☐ Medical Reason ☐ Religious Reason ☐ Personal Reason
4. Date Immunizations verified by: _____
   ☐ Physician Record ☐ Parent Record ☐ Health Dept. Record

My student has had the chickenpox disease, and therefore, does not need the Varicella vaccine.

Signature of Parent/Guardian:

_____

Date of Disease: _____

Today's Date: _____

I have reviewed the records available, and to the best of my knowledge, the student has received the above immunizations.

Authorized Signature: _____ Date: _____

TO: Parents/Guardians
FROM: Medical Department

Provo Campus Medical Department 801-227-2003
Springville Campus Medical Department 801-704-1373

The medical department would like to welcome you to Provo Canyon School. We want you to know that we have a medical unit with doctors and nurses on staff, therefore all medical concerns will be coordinated through the nursing department. We have on staff licensed independent practitioners who will be seeing patients with any medical concerns. On admission all patients are given a complete physical including a pelvic or genital examination. In addition we request the date of your child's last dental exam and have enclosed a permission form for you to complete. It is our policy that any patient requesting to see a specialist should first be screened by our licensed independent practitioner for evaluation of the condition.

Please fill out the medical forms as accurately as possible. Include all current and history of previous medications prescribed on the form. This information helps the transition process until our physicians are able to evaluate your child and prescribe or change the medication, if needed. Also include copies of (front and back) of your current medical, dental and prescription cards. It is important that you still fill out the dental and medical insurance portion of the applicant information form. Please fill out completely the mother/father portion of the applicant form including dates of birth especially for the person who carries the insurance. This will facilitate the insurance being billed correctly and so you won't be receiving unnecessary bills from doctor offices.

Current, properly labeled prescription medications should be sent on admission. Medications will be ordered from our pharmacy upon arrival of the patient at PCS. If you need the name of a primary care physician in this area to insure coverage of your son/daughter by your medical insurance or if your child will need to use mail order prescriptions please contact the medical department and they will direct you to the appropriate parties.

All patients attending Utah schools are required to have a complete immunization record on file upon admission, which includes a Varicella Vaccine and the Hepatitis B Series. This is a mandatory State Law**.** We have attached the necessary papers to document this information. Please complete and sign the Utah School Immunization Record including the box on the lower right regarding the Varicella (Chicken Pox) history. This box needs to be signed by the parent/guardian if your child has had the chicken pox disease.

If we do not receive immunization records or do not receive a denial of permission which is a signed waiver from the Utah County Health Department (801) 851-7044 **within 30 days** we will administer immunizations necessary to bring your child into compliance with state law. The cost for these immunizations will be billed to your account. The immunizations can be quite costly some examples of current prices are as follows:

Varicella (Chicken Pox)	$78.00	MMR	$51.00	IPV (Polio) $33.00
TDAP (Tetanus, Pertussis)	$49.00	HBV (Hep. B)	$35.00	

Please feel free to contact the medical department at any time. We appreciate hearing from you.

I have read and understand the procedures outlined above:

Parent/Guardian Signature: _____ Date: _____

IMPORTANT INSURANCE INFORMATION

I understand that some insurance policies (especially HMO policies such as Medi-Cal & Kaiser) will not cover medical expenses outside of their state. This means that any medical expenses accrued while at Provo Canyon School will not be covered. This includes but is not limited to any prescriptions that my child may need while here. I understand that it is my responsibility to verify my medical and prescription benefits to see whether I have coverage outside my local area.

However, I understand that I may set up mail-order for my child's medications, in which the physician's at Provo Canyon School will write the prescription and send it to me. I may need to take the prescription to my child's doctor and request that he/she rewrite the prescription. I should have the prescription filled and returned to Provo Canyon School in a timely manner. I understand that if the prescription is not received by the time the medication that my child needs runs out, that the medical department at Provo Canyon School will have the prescription refilled and that I will be responsible for the cost. Provo Canyon School will try to notify the parent/guardian to let them know when this needs to happen. When possible we order one week at a time until the mail-order medication is delivered.

I understand that I am responsible for getting a copy of my insurance cards to the medical department. If I do not submit the copy by the admission date, I will be responsible for medical expenses that may accrue until we receive copies of the insurance cards.

I understand my insurance plan benefits. I understand I am responsibility for any deductibles, co-insurance, or co-payment amounts prior to any admission.

It is further understood by all parties to this agreement the parent/guardians have full responsibility for payment of all cost to complete a treatment plan. Therefore, should a third party payer or review agency withdraw certification/financial support for any reason, the guardian/parent has the right to withdraw student from the program without further financial obligation, or they may keep the student in the program and assume full financial obligation from the date of said withdrawal.

I understand that I am responsible for making sure that my insurance remains active and that I am financially responsible for any charges incurred if it is not active or eligibility expires.

Parent/Guardian Signature: _____ Date: _____

PREMIERE CARE PHARMACY
450 W. 800 N. Orem, UT 84057
801-225-2150 / 801-225-2155 / Fax: 801-225-2388

Agreement for Services

Salmon Pharmacy is contracted to provide the majority of the prescription medication for patients of **Provo Canyon School.** Premiere Care Pharmacy will bill all agencies or insurance companies when applicable. However, the guarantor or legal guardian will be responsible for any deductibles, copays, coinsurance, or non-covered charges. The following agreement must be completed, signed, and returned to Premiere Care Pharmacy prior to service.

PATIENT INFORMATION (Please Print)

Name:_____SSN: _____ Date of Birth: _____
Male/Female: _____ Allergies: _____

PAY SOURCE INFORMATION

( ) Self-Pay ( ) Self-Pay With Insurance ( ) Medicaid ( ) Other

Insurance Company: _____ Insurance Address: _____ Phone: _____
Policy Number: _____ Group Number: _____ BIN No: _____
Policy Holder (if different from patient): _____

******Please send a copy of the insurance card (front and back)******

GUARANTOR INFORMATION (Please Print)

Name: _____ SSN: _____ Date of Birth: _____
Relationship to Patient: _____ Home No: _____ Work No: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Employer Name/Address: _____

METHOD OF PAYMENT

( ) CHARGE my VISA, MASTER CARD, DISCOVER CARD, or AMERICAN EXPRESS on the first day of each month.
Card Type: _____ Account No: _____ Exp. Date: _____
Cardholders' Signature: _____ Today's Date: _____

( ) DEPOSIT ($200.00) self-pay with no insurance; $100.00 self-pay with insurance; $25.00 Medicaid. Required at the time of admission, made payable to Premiere Care Pharmacy. By signing this form, I understand that I am responsible to maintain a credit balance on this account to cover future medication charges. I understand that medications will not be dispensed on a credit basis. I understand that Salmon Pharmacy will mail a monthly itemized statement that will reflect the account balance. Any remaining credit balance will be refunded in full within 30 days of the last day of the month of discharge.

GUARANTEE OF PAYMENT

I, the undersigned, authorize Premiere Care Pharmacy access to the above-mentioned patient's medical records for proper medication assessment. I agree to pay and guarantee the prompt payment in full within 20 days from any indebtedness, obligations and liabilities owing to Salmon Pharmacy and/or its agents by the above-mentioned patient, including, but not limited to, medication, medical supply, equipment, and finance or interest charges at the rate of 18% per month on the unpaid balance. In addition, I agree to pay and guarantee all reasonable attorney's fees, court costs, and costs of collection, with or without legal action.

GUARANTOR SIGNATURE: _____ **DATE**: _____
Signer must be the same as the Guarantor listed above

Utah County
HEART of UTAH
Health Department

Provo Canyon School
IMMUNIZATION ENCOUNTER FORM

Health Insurance? ☐YES ☐NO **Please have insurance information ready to present**

Patient Name: (First, Middle Initial, Last) _____

Date of Birth: ____/____/____ **Age:** _____ **Gender:** ☐Male ☐Female **Phone #:** _____

Address: _____ #: _____ **City:** _____ **State:** _____ **ZIP:** _____

Race: ☐White ☐Alaskan Native ☐Black or African American ☐Native American ☐Asian/Pacific Islander ☐Other
Ethnicity: Hispanic ☐YES ☐NO

Screening Questions for Today's Immunizations ***Please answer these question concerning the individual receiving immunizations today by checking the boxes below***	Yes	No	Don't Know
Sick today?			
Do you have any chronic diseases? Child < 5 years of age with recurrent wheezing?			
Have allergies to medications, food, latex or any vaccine?			
Had a serious reaction to a vaccine in the past?			
Ever had a seizure, brain, Guillain-Barre syndrome, or other nervous system problem?			
Has or lives with someone that has cancer, leukemia, AIDS, or any other immune system problem?			
Taken cortisone, prednisone, other steroids, or anti-cancer drugs, immunosuppressive medication, or had radiation treatments in the past 3 months? Child or adolescent taking aspirin?			
Received transfusion of blood or blood products, or been given an immune (gamma) globulin in the past year?			
Pregnant or at risk of becoming pregnant within the next month?			
Received any vaccinations in the past four weeks?			
Ever had Chickenpox?			

I have been given a copy and have read or had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I certify that I have received a copy or been given the opportunity to read the Notice of Privacy Practices. I agree that the information on this form may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release the Utah County Government and their employees from all claims arising from such immunizations. I understand that if I have insurance that covers vaccines, I am not eligible for the Vaccine for Children program. I hereby authorize the Utah County Health Department to submit claims to my Medicaid, Medicare, and/or UCHD contracted insurances.

I understand that my health insurance coverage could have certain restrictions and limitations. I agree to pay the full amount for any and all related charges, if they are not covered by my insurance for any reason. If I fail to pay for these services and charges within 90 days of receiving notice that the charges are not covered for any reason, my account will be turned over to a collection agency. I hereby expressly agree to pay all costs of collection fees including an additional collection of 35%. I further agree to pay all court costs and attorney's fees should legal action become necessary.

Due to the higher cost to provide insurance billing services, I understand that the amount billed to my insurance company is higher than the discounted amount I would have paid if I had chosen to pay at the time of service. I understand that I will be charged the full cost of the vaccines if I do not pay today and my insurance company does not cover the costs for any reason. I hereby request and authorize the Utah County Health Department to submit claims to my Medicaid, Medicare, and/or UCHD contracted insurances.

JURISDICTION AND VENUE The terms and conditions contained within this agreement shall be governed by the laws of the State of Utah and shall be construed and interpreted in accordance with those laws. Any action or proceeding brought by either party which is based upon or derived from, or in any way related to this agreement shall be brought in a court of competent jurisdiction within the state of Utah. The parties hereto consent to their personal jurisdiction of said court.

Authorization Signature: _____ Date: ____/____/____ Relation, if other than self_____

Please Print Name: _____

Date printed on Vaccine Information Sheet: MULTIPLE VACCINES; DTAP/DT 05/17/07; HEP A 10/25/11; HEP B 02/02/12; HIB 04/02/15; HPV 05/17/13; HPV9 04/15/15 IG 05/1/94; INFLUENZA 08/19/14; MENINGO 10/14/11; MMR 04/20/12; MMRV 05/21/10; PNEU23 10/06/09; PNEU 13 02/27/13; POLIO 11/08/11; PPD 04/25/05; RABIES 10/06/09; ROTAVIRUS 08/26/13; SHINGLES 10/06/09; TD 02/24/15; TDAP 02/24/15; TYPHOID 05/29/12; VARICELLA 03/13/08; YELLOW FEVER 03/30/11; JE 01/24/14

CODE	VACCINE	CATEGORY	SITE	LOT #	DOSE	COST	PAYMENT INFORMATION
							Cash/Check/Visa or MasterCard/Contract
							INSURANCE:
291	Total Costs for Today's Vaccines/Insurance Provider:						Total Amount Paid:
Nurse One ID #			Nurse Two ID#				Operator ID#:
Wait 15 min ☐	Live Vaccine ☐	Notes:					