

**LADYSMITH INTERNATIONAL STUDENT PROGRAM
APPLICATION FORM (AGENCY SPONSORED)**

Please type or write in black ink.

Program: School Year (10 months)
 1st Semester (September-January)
 2nd Semester (January-June)

International Agency: _____

Nickname: _____

Applicant's family name (as shown on passport)	First Name	Middle Name
Street Address	City	State/Province
Postal Zone/Code	Country	Home Telephone (with Country/city codes)
E-mail Address	Fax Number	Emergency Contact Name and Telephone Number
Country of Legal Residence	Nationality on Passport Passport #/Expiration	
Date of Birth (month/day/year)	Age	U.S.A. Emergency Contact Name and Telephone Number
City/State or Providence/Country of Birth	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	

Family Information (Please include names, ages and occupations of your family members)

Father	Living in household? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sister(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brother(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Religion: _____ How often do you attend services: weekly monthly occasionally holidays
 never

Do you have food allergies? Yes No If yes, please provide details:

Do you follow a special diet? Yes No If yes, please indicate: vegetarian kosher other: _____

Do you have any non-food allergies? Yes No If yes, please describe:

Have you had any type of work or volunteer experience? Please describe:

How many years have you studied English? _____

SLEP Score: _____ Date: _____ TOEFL Score: _____ Date: _____



LIABILITY RELEASE

We grant the Ladysmith High School and its designated employees where the student will be assigned, and the resident director or host with whom he/she may live that, at their discretion, and if necessary, at the cost of the participant or his/her parents or legal guardians—in the case of expenses exceeding the coverage of the insurance policy covering the student—the power to place him/her under the care of a local medical doctor for his/her treatment. We also grant the Ladysmith High School and its designated employees where the student will be assigned, and the resident director or host he/she may live, all necessary permissions to act as legal guardians and “in loco parentis” in any situation, especially in emergencies, whether medical or other, including the possibility of permission for surgical operations or any other treatment.

We also authorize the Ladysmith High School and its designated employees where the student will be assigned, and the resident director or host he/she may live, to return him/her to his/her country of origin at his/her own cost or that of his/her parents or legal guardians, if necessary, to submit to medical treatment, if this is deemed necessary by the above mentioned people, after consultation with medical authorities. We confirm that at the time of signing this document, the student enjoys perfect health, and that his/her health record enclosed herewith is true and complete.

We also grant the Ladysmith High School and its designated employees where the student will be assigned, and the resident director or host families with whom he or she may live, permission to act on our behalf in anything pertaining to possible representation before the local authorities.

This authorization shall be valid for the entire duration of the Ladysmith International Student Program in which the student is participating.

Student’s Name (Please print) : _____

Parent’s signature: _____ Date: _____



PROGRAM RULES

Any infraction of the rules below will result in immediate dismissal from Ladysmith High School and placement of your Visa in jeopardy:

1. Students must abide by all laws of the United States.
2. It is against the law in the United States for high school students to buy or drink alcohol. This law applies to all foreign exchange students as well. The legal age for buying and consuming alcohol in the United States is 21.
3. The use of drugs for non-medical reasons by students under any circumstances is strictly forbidden. Some examples of non-medical (illegal) drugs are cocaine, LSD, methamphetamine, and marijuana.
4. Students are not permitted to hitchhike. Students are not permitted to purchase, carry, or use firearms under any circumstances.
5. Students are not permitted to hold part-time jobs; there are strict rules governing employment for International Students. A non-immigrant alien who accepts paid employment is subject to deportation. If students would like to earn spending money during their stay, they are permitted to hold small jobs (no more than 10 hours per week) such as baby-sitting, grass-cutting, and newspaper delivery.
6. Students are not permitted to drive any motor vehicle (including motorcycles, mopeds, snowmobiles, and cars) except during the course of an accredited driver education class. Students may enroll in a school-sponsored driver education class if their natural parents permit it.
7. The stealing or taking any item or property of others is against the law and is strictly prohibited. If it does NOT belong to you leave it alone.

Any continuous failure to abide by the following rules along with the dorm and school rules may result in dismissal from the program and place their Visa in Loss of Status:

1. The legal age for buying cigarettes in the United States is 18. Smoking at school or the dorms is not permitted. If you have indicated that you are a non-smoker on your application and you do in fact smoke at your residence, you will automatically be placed on probation.
2. Students must always be aware of their responsibility as exchange students and as such make a determined effort to be a positive ambassador for their home country in their school, residence, and host community.
3. Students must attend school daily unless sick and/or under a doctor's care or with special permission from the head resident. Students must complete all homework and assignments.
4. Students must be full time students and maintain a "C" average or better in all classes. Students must also enroll in an appropriate English language or literature course and an American Social Studies course. Failure to maintain a "C" average will result in academic probation.
5. Students are not permitted to visit such places as pornographic shops, adult theaters, drinking establishments, or any web sites related to pornography or gambling.
6. Students must show respect for their Community Connection and participate in scheduled activities. Students are not allowed to stay alone at their Community Connection's residence.
7. Students must abide by all dorm and Community Connection residence rules and must help with dorm and household chores as assigned.
8. Students cannot change residence or schools at will.

9. Students are allowed to travel only if accompanied by a responsible adult (21 years of age or older) and have written approval by their natural parents or international agency and have LISP approval. The trip may not involve missing any school (except for school-sponsored trips) without a pre-arranged absence. Independent travel by participants is not permitted during this program.

10. Students may not have sexual relationships, or sexual contact with others, nor openly display affections.

11. Students must read the Ladysmith International Student Program Handbook and agree to abide by the rules, expectations, regulations, etc. which are contained therein. It is the student's responsibility to know the rules outlined here and within the LISP Handbook. These rules are for the safety and well-being of all students attending Ladysmith High School. Students are expected to cooperate by following these rules and we encourage students to ask LHS or LISP personnel to explain the rules if necessary.

SCHOOL RECORDS

At times throughout the school year, it may be necessary to release school records to other educational institutions or government agencies. You are agreeing to the authorization to release school records in accordance to school policy.

PROGRAM TERMINATION

LISP reserves the right to terminate program participation for the violation of any program, residence, local, state, and/or federal rules and/or when a student's mental and/or physical health (as determined by a physician or LHS/LISP administration) is in jeopardy. We, the participant and his/her parents, have read and understand all of the above. As a participant, I agree to obey these rules. I understand that disobeying the rules/regulations will result in my termination from the program, the loss of full program fees, and I will be returned to my home country at my own expense.

TRAVEL AUTHORIZATION

We as parents of the Undersigned student, do hereby authorize the Ladysmith High School—Ladysmith International Student Program (LHS/LISP) Director, and/or Resident Director as our agents to determine our student's travel for the length of his/her program. It is understood that his/her authorization is given in advance when the student is traveling and supervised by a resident assistant, designated Community Connection parent, or by a representative of a LISP/school program. **We understand and agree that our student may not travel unsupervised, unless we have signed the Unchaperoned Off-Campus Authorization.**

REFUND POLICY

No refunds will be granted if a student transfers an I-20 to another high school or exchange program at his/her own initiative. In addition, no refunds will be granted should it become necessary to send a student home for rule violations or behavior issues.

I have read and understand the above information and agree to the terms and conditions set forth. This includes all information contained within the LISP Handbook.

Student Name (Please print): _____

Student Signature: _____ Date _____

Parent Signature: _____ Date _____



TRAVEL AUTHORIZATION

We as parents of the Undersigned Student, do hereby authorize the Ladysmith International Student Program (LISP) Coordinator, and/or resident director as our agents to determine the student's travel for the length of his/her program. It is understood that his/her authorization is given in advance only when the student is traveling and supervised by a resident director, designated host parent or by a representative of a school program. We understand that the student may not travel unsupervised.

DRIVING

LISP does not condone the driving of any automobile in the United States of America by its participants, except as part of an approved Drivers Education and training course. Students can be dismissed from the LISP program for a violation of this policy.

Drivers Education Permission:

(Please check) We give our full consent for our son/daughter to take a driver's education course (if available) during his/her stay in the U.S. on the LISP program. Most school-sponsored courses provide insurance coverage; however if it is necessary to obtain additional insurance this will be our responsibility. I understand that while my son/daughter may be allowed to obtain a drivers license, he/she will not be permitted to drive outside of an approved class.

The student is liable for the cost of the driver's education program.

(Please check) We do not give our consent for our son/daughter to take a driver's education course (if available) during his/her stay in the U.S. on the LISP program.

Student's Name (Please print) : _____

Parent's signature: _____ Date: _____



363.3-EXHIBIT (1)
INTERNET WEB PAGES
DISTRICT WEB SITE

**SCHOOL DISTRICT OF LADYSMITH
PERMISSION FORM FOR WORLD WIDE WEB (INTERNET) PUBLISHING
OF STUDENT WORK OR PICTURE**

____ Student Work (Please check)

We understand that our student’s work or writing may be considered for publication on the World Wide Web, a part of the Internet. We further understand that any student work will appear with a copyright notice prohibiting the copying of such work without express written permission. In the event anyone requests such permission, those requests will be forwarded to us. No home address or telephone number will appear with such work. Only the student’s first name will be used when publishing their work.

____ Student Picture (Please check)

We understand that our student’s picture may be considered for publication on the World Wide Web, a part of the Internet. If a picture of the student is used, the first name only will appear with the picture. This includes any team or club pictures.

We grant permission for the World Wide Web publishing as described and checked above until the end of the _____ school year. Such permission releases the School District of Ladysmith, School Board, or employees from any and all liability and legal or equitable claims related to student work being published on the district web site.

Parent/Guardian: _____ Date _____

I, the student, also give my permission for such publishing.

Student Name (Please print): _____

Student Signature: _____ Date _____

We DO NOT grant permission for the World Wide Web publishing as described above.

Parent/Guardian: _____ Date _____

Student Signature: _____ Date _____

BOARD APPROVED:



UNCHAPERONED OFF-CAMPUS RULES FOR LISP STUDENTS

Here at Ladysmith High School and Ladysmith International Student Program, we care about the safety and security of our students. Consequently we have established rules and protocols for any un-chaperoned off-campus activities.

If you wish to go off-campus without an approved adult chaperone, you must always:

- (1) obtain permission from a dorm supervisor – **must sign out at the dorm**
- (2) let us know where you are going and when you will return; and
- (3) participate in our buddy system (you must be with a “buddy” – not alone – when off campus)
- (4) keep a cell phone with you (either your own or one from the dorm)

You may leave the campus only during the following designated hours:

Monday through Friday: 4-7:30 pm

Saturday, Sunday and non-school days: 10 am–10 pm

When you request to go off campus, please have the following information ready:

- (1) the name of your buddy (if you need a buddy, you can sign up to request one on our buddy system bulletin board, for shopping trips, etc.)
- (2) your specific destination (store, restaurant, sport event, etc.)
- (3) if your destination is a friend’s home:
 - friend’s name
 - parent’s name, or name of adult chaperone who will be present, and phone number (dorm supervisor may call to verify)
 - nature of visit (hanging out; party; lunch; etc.)
- (4) if your destination involves riding in a car:
 - driver’s name, age, and car license number
 - parent’s name and phone number (dorm supervisor may call to verify)
 - other passengers in the car, if any
- (5) your intended return time (you will be expected to return at or before this time; if for any valid reason you will be late, you must call to notify a resident assistant)
- (6) your cell phone number (or you may borrow one from the dorm)

The following activities are strictly **forbidden**: hitchhiking; driving or operating a motorized vehicle (including motorcycles, mopeds, four wheelers, snowmobiles, and cars) except during the course of an accredited driver’s education class; shoplifting or stealing (taking another person’s property); vandalism (including destroying property, graffiti or other destructive behavior); alcohol or drugs; and any other activities deemed inappropriate by LISP staff.

Any infraction of the rules above will result in the loss of off campus privileges for a minimum of one week. Subsequent violations will be cause for further restrictions, up to and including dismissal from the Ladysmith International Student Program.

PROGRAM TERMINATION

LISP reserves the right to terminate program participation for the violation of any program, residence, local, state, and/or federal rules and/or when a student’s mental and/or physical health (as determined by a physician or LISP administration) is in jeopardy. Incidents of inappropriate conduct or inappropriate public display will be investigated by LISP personnel and may lead to disciplinary actions. As the participant, I have read and understand all of the above and I agree to obey these rules. I understand that disobeying will result in my termination from the program, loss of full program fees and the possible return to my home country at my own expense.

I have read and understand the above information and agree to the terms and conditions set forth, including all information contained within the LISP Handbook.

Student Name (Please print): _____

Student Signature: _____ Date: _____

I have read and understand the above information and agree to the terms and conditions set forth, including all information contained within the LISP Handbook. I authorize my student to take part in the Unchaperoned Off-Campus Rules for LISP Students.

Parent/Guardian Name (Please print): _____

Parent Signature: _____ Date: _____



1/20/2012

Dear Parent/Guardian:

It has been a pleasure working with your son or daughter thru the Ladysmith High School International Program. The School District of Ladysmith Medical Advisor has developed Standing Orders for the Administration of Medication for the International Program. All of these medications are over the counter non prescription medications. We have listed a variety of health needs (issues) common to the American school age population.

At this time the School District of Ladysmith will not administer any medications brought to the United States by your child due to school policy. Unfortunately, many non-prescription and prescription medications brought by the students are unable to be read as they are written in the student's native language. Obviously, this prevents us from knowing what the medication is used for and the proper dosage to be given. All prescription drugs **MUST BE IDENTIFIED AND WRITTEN IN ENGLISH INCLUDING THE DOSAGE!** The Standing Orders allows us to administer medications to your son or daughter if they present any of these symptoms. If there are other health concerns the district nurse will refer your son or daughter to a health care provider here in Ladysmith.

Please review the attached Standing Orders. If you agree for your son or daughter to receive any of these medications during the course of the school year please sign and date. If you have any questions please feel free to contact me at the high school, 715-532-5531, Ext. 273.

Thank you.

Sincerely,

Cynthia A. Krings RN, BSN
School District of Ladysmith Nurse
ckrings@lhsd.k12.wi.us

Standing Orders for Medication Administration 2012-2013

Allergies	Loratadine (Claritin) 10mg 1 tablet daily for sneezing and runny nose Benadryl 25mg 1-2 capsules every 6-8 hours as necessary for sneezing and runny nose
Cold & Congestion	Decongestant Pseudoephedrine 30mg 1 tablet every 4-6 hours PRN for nasal congestion
Car Sickness	Dramamine 1 tablet every 8 hours (should be administered prior to a long bus ride/car ride)
Constipation	MiraLax 1 cap full in 8 ounces of clear liquids daily
Cough	Robitussin (generic dextromethorphan) 2 teaspoons (10cc) every 4-6 hours as necessary for cough Cough drop 1 every 2-3 hours
Cuts/Abrasions/Scrapes/Burns	Triple Antibiotic Ointment 2-3 times per day or as needed; cover with a bandaid and assess for infection
Diarrhea	Imodium 2 tablets following the 1 st loose stool; 1 tablet every 8 hours as needed for diarrhea
Digestion/Gas/Stomach Discomfort	Tums 2 chewable tablets every 4 hours as necessary for upset stomach & heartburn
Eye Irritation	Artificial Tears 2-3 drops to each eye as needed
Fever	Tylenol Extra Strength 2 tablets every 4 hours for fever
Headaches	Ibuprofen 200mg 2 tablets every 4-6 hours (should not be given on an empty stomach) or Tylenol 500mg 1-2 tablets every 4-6 hours
Menstrual Cramps	Ibuprofen 200mg 2-3 tablets every 4-6 hours as necessary for menstrual cramps (should not be administered on an empty stomach)
Pain/Aches/General Discomfort	Acetaminophen (Tylenol) 500mg 1-2 tablets every 4-6 hours
Rash/Itching	1% Hydrocortisone Cream topically 3-4 times daily

School District of Ladysmith Medical Advisor

Date

Parent/Legal Guardian Signature

Date



MEDICAL RELEASE AUTHORIZATION

We, as parents/guardians of the undersigned student, hereby authorize the resident director host or school official to consent to any medical diagnosis, treatment or care which a licensed doctor or dentist deems to be medically necessary for our son/daughter while he/she is participating in this exchange program. In addition, we authorize LISP and Ladysmith High School to provide my child with a physical examination for the purposes of participating in school sponsored athletics.

It is understood that this authorization is not given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the host resident director or school official to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician/dentist or surgeon in the exercise of his/her best judgment may deem advisable. We also grant permission for our child to receive any and all immunizations required by federal, state, local, or school authorities. All medical expenses will be assumed by the student's legal parents/guardians.

Parent's name: _____
(Please print)

Parent's signature: _____ Date: _____

Student's name: _____
(Please print)

Student's signature: _____ Date: _____

Medical Insurance Information:

Name of Company: _____

Phone Number: _____ - _____ - _____

Policy Number: _____

Insurance Contact Information: _____

Consent for Treatment of Minors in Parent/Legal Guardian Absence Page 1 of 1

To comply with Wisconsin law, Marshfield Clinic 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 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/behavioral health/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

I/We (parent's name) _____ authorize

Appointee's name _____

Relationship _____

Appointee's address _____

Appointee's phone number _____

to consent to:

___ Emergent or urgent care at Marshfield Clinic when I cannot be reached.

___ Medical and dental care at Marshfield Clinic including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia, except for a local anesthetic.

___ Any and all necessary medical/dental and surgical care and treatment at Marshfield Clinic.

for my child:

Child's name _____ Child's MHN _____

during the period:

___ Date (month/day/year) _____ / _____ / _____ to _____ / _____ / _____

___ For a maximum period of 1 year

___ Marshfield Clinic providers should attempt to contact me before providing care at the following numbers:

Home phone _____ Work phone _____ Cell phone _____

I further agree to reimburse Marshfield Clinic/health care provider for the cost of rendering these services to the extent that my insurance does not pay for these services.

Patient signature (person authorized to consent for patient)

(relationship)

Child's parent/legal guardian address

Date (month/day/year)

Patient name			
MHN	DOB	Age	Gender

Release or Share

Release of Information Authorization

Page 1 of 3

NOTE: This authorization will be returned and records will be delayed if all sections are not completed. Use BLACK or BLUE ink.

Patient	Previous last name (if any)																					
	Address		Daytime phone number																			
	City	State	ZIP																			
Who has the information that is to be released	Name <i>Marshfield Clinic / Rush County Memorial Hospital</i>		Phone number <i>715-532-5561</i>																			
	Address <i>@</i>		Fax <i>715-532-2300</i>																			
	City	State	ZIP																			
Whom should the information be released to	Name <i>Robert King, Cindy King, Stacy Ojert</i>		Phone number <i>715-532-5531, Ext 293</i>																			
	Attention <i>Ladywood High School</i>		Fax <i>715-532-5961</i>																			
	Address <i>1700 Edgewood Av. East</i>																					
	City <i>Ladywood WI</i>	State <i>WI</i>	ZIP <i>54848</i>																			
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: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Medical history and notes</td> <td><input type="checkbox"/> Consults</td> <td><input type="checkbox"/> Surgical reports</td> </tr> <tr> <td><input type="checkbox"/> Laboratory/Pathology reports</td> <td><input type="checkbox"/> Prescriptions</td> <td><input type="checkbox"/> Hospital records</td> </tr> <tr> <td><input checked="" type="checkbox"/> Billing/Financial records</td> <td><input type="checkbox"/> Correspondence</td> <td><input type="checkbox"/> X-ray reports</td> </tr> <tr> <td><input type="checkbox"/> HIV/AIDS test results</td> <td><input type="checkbox"/> School records</td> <td><input type="checkbox"/> Other diagnostic tests</td> </tr> <tr> <td><input type="checkbox"/> Immunizations</td> <td colspan="2"></td> </tr> </table>			<input type="checkbox"/> Medical history and notes	<input type="checkbox"/> Consults	<input type="checkbox"/> Surgical reports	<input type="checkbox"/> Laboratory/Pathology reports	<input type="checkbox"/> Prescriptions	<input type="checkbox"/> Hospital records	<input checked="" type="checkbox"/> Billing/Financial records	<input type="checkbox"/> Correspondence	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> HIV/AIDS test results	<input type="checkbox"/> School records	<input type="checkbox"/> Other diagnostic tests	<input type="checkbox"/> Immunizations						
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<input type="checkbox"/> By specific doctor, for a specific diagnosis or a specific date range _____ <input checked="" type="checkbox"/> Other, specify <i>any/all medical evaluations, treatments, all physicians records!</i>																						
	Mental health/alcohol & other drug abuse/neuropsychology records: <i>including future records</i>																					
	<table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Mental health</td> <td>AND/OR</td> <td><input type="checkbox"/> Alcohol & other drug abuse</td> <td>AND/OR</td> <td><input type="checkbox"/> Neuropsychology</td> </tr> <tr> <td><input type="checkbox"/> Consult</td> <td></td> <td><input type="checkbox"/> Medication treatment</td> <td></td> <td><input type="checkbox"/> Correspondence</td> </tr> <tr> <td><input type="checkbox"/> Testing evaluation</td> <td></td> <td><input type="checkbox"/> Discharge summary</td> <td></td> <td><input type="checkbox"/> Treatment notes</td> </tr> <tr> <td><input type="checkbox"/> Emergency room note</td> <td></td> <td><input type="checkbox"/> Treatment plan</td> <td></td> <td><input type="checkbox"/> Evaluation</td> </tr> </table>			<input type="checkbox"/> Mental health	AND/OR	<input type="checkbox"/> Alcohol & other drug abuse	AND/OR	<input type="checkbox"/> Neuropsychology	<input type="checkbox"/> Consult		<input type="checkbox"/> Medication treatment		<input type="checkbox"/> Correspondence	<input type="checkbox"/> Testing evaluation		<input type="checkbox"/> Discharge summary		<input type="checkbox"/> Treatment notes	<input type="checkbox"/> Emergency room note		<input type="checkbox"/> Treatment plan	
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Medical or other records to be shared with relatives or other persons Check (✓) box(es) to indicate the information you want shared	<input type="checkbox"/> Medical treatment information can be disclosed: written or verbal communication, voice mail, appointment verification (excluding mental health treatment, AODA treatment, HIV test results).																					
	And/Or check individual items below that can be shared: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Mental health treatment notes</td> <td><input type="checkbox"/> My Marshfield Clinic – online health management</td> </tr> <tr> <td><input type="checkbox"/> Alcohol and other drug therapy</td> <td><input type="checkbox"/> Treatment of HIV/AIDS, including test results</td> </tr> <tr> <td><input type="checkbox"/> Neuropsychology notes</td> <td><input type="checkbox"/> Obtain copies or authorize release of my medical records</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Billing information about my account which may include health information</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> My spouse or parent (a physician at Marshfield Clinic) can access my electronic medical record (EMR)</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Specific information as follows: Diagnosis _____</td> </tr> <tr> <td>Provider _____</td> <td>Date range _____</td> </tr> </table>			<input type="checkbox"/> Mental health treatment notes	<input type="checkbox"/> My Marshfield Clinic – online health management	<input type="checkbox"/> Alcohol and other drug therapy	<input type="checkbox"/> Treatment of HIV/AIDS, including test results	<input type="checkbox"/> Neuropsychology notes	<input type="checkbox"/> Obtain copies or authorize release of my medical records	<input type="checkbox"/> Billing information about my account which may include health information		<input type="checkbox"/> My spouse or parent (a physician at Marshfield Clinic) can access my electronic medical record (EMR)		<input type="checkbox"/> Specific information as follows: Diagnosis _____		Provider _____	Date range _____					
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Provider _____	Date range _____																					

Release or Share

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender
Radiology films, pathology slides, or photographs to be disclosed	<p>Check (✓) boxes below for the films, slides or photographs to be released per this request:</p> <p><input type="checkbox"/> Original x-ray of _____ <input type="checkbox"/> Mailed date (m/d/y) ____ / ____ / ____</p> <p><input type="checkbox"/> Photographs (Return loaned films/slides within 30 days)</p> <p>(define type _____) <input type="checkbox"/> Pick up date (m/d/y) ____ / ____ / ____</p> <p><input type="checkbox"/> Pathology slides of _____ By _____</p>			
Special medical record release by minor	<p>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.</p> <p>Check (✓) boxes of medical records to be disclosed:</p> <p><input type="checkbox"/> Outpatient alcohol or other drug dependency care (12 years or older) (parent may also be required to sign below)</p> <p><input type="checkbox"/> Inpatient alcohol or other drug dependency care – detoxification only (12 years or older) (parent may also be required to sign below)</p> <p><input type="checkbox"/> Rape or sexual assault/abuse (12 years or older) (parent may also be required to sign below)</p> <p><input type="checkbox"/> Outpatient mental health care (14 years or older)</p> <p><input type="checkbox"/> Inpatient mental health care (14 years or older)</p> <p><input type="checkbox"/> Neuropsychology notes (14 years or older) (parent may also be required to sign below)</p> <p><input type="checkbox"/> HIV/AIDS test results (14 years or older)</p> <p><input type="checkbox"/> Sexually transmitted disease (17 years or younger)</p> <p><input type="checkbox"/> Pregnancy test (17 years or younger) (parent may also be required to sign below)</p> <p><input type="checkbox"/> Birth control pills or devices (17 years or younger) (parent may also be required to sign below)</p> <p><input type="checkbox"/> Pregnancy-related care or care of newborn (17 years or younger)</p> <p><input type="checkbox"/> My parent (a physician at Marshfield Clinic) can access my electronic medical record (EMR) (parent may also be required to sign below)</p> <p>_____ Patient signature</p> <p style="text-align: right;">_____ Date (m/d/y)</p>			
Method of release	<p><input type="checkbox"/> Electronic (via CD/DVD) <input type="checkbox"/> Paper</p> <p><i>Note: Information supplied via CD/DVD is in PDF format and is not encrypted.</i></p>			
Reason for the release	<p>Check (✓) box below to indicate the reason for the release per this request:</p> <p><input checked="" type="checkbox"/> Continuing health care needs <input type="checkbox"/> Preemployment or medical evaluation</p> <p><input type="checkbox"/> Disability <input type="checkbox"/> Billing, collection or payment of claims</p> <p><input type="checkbox"/> Transfer of care <input type="checkbox"/> Postemployment testing or medical</p> <p><input type="checkbox"/> Care coordination or case management <input type="checkbox"/> Employment determination (nonwork-related illness or injury)</p> <p><input type="checkbox"/> Second opinion/referral <input type="checkbox"/> Litigations</p> <p><input type="checkbox"/> Personal <input type="checkbox"/> Other, specify _____</p> <p><input type="checkbox"/> Financial assistance</p>			

Release or Share

Release of Information Authorization (Continued)

Patient name		MHN	DOB	Age	Gender
Expiration Check (✓) box below to indicate the expiration per this request	This authorization will remain in effect:				
	<input type="checkbox"/> From the date this authorization is signed until the ____ day of _____, 20 ____ <input type="checkbox"/> Until you cancel this authorization in writing. <input type="checkbox"/> Until the following event occurs, specify event _____ <input checked="" type="checkbox"/> Other, specify <u>1 year from date of signature or age 18</u>				

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)



____ / ____ / ____
Date (m/d/y)



Phone number

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, 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.



TO: International Student Exchange Agency and/or Parent/Guardian

FROM: LISP Administration

DATE: 1/26/2012

RE: Athletic Participation

On the following 4 pages you will find the Wisconsin Interscholastic Athletic Association (WIAA) 4 page form which a portion of page 4 needs to be completed by the legal parent/guardian. Please print off the form and have the parent/guardian sign at the bottom of **page 1 and page 4**. (All forms must be completed in English.)

The following are the directions for completing the forms which is required in order to participate in Wisconsin's Interscholastic Athletic (sport) competitions:

- 1.) Your student will complete page 1, but **you must sign** at the bottom of page 1. Ladysmith High School (LHS) will fill in the date of the physical examination.
- 2.) **Please disregard page 2** - this page is only used for students with special educational needs.
- 3.) Page 3, this portion of the application must be completed by the US physician when we take the students for their physical. Currently, the cost of the physical is \$118.00.
- 4.) Page 4, please fill in the areas of the form which asks for: the parent's place of employment, the name of your Family Physician, the name of your Private Insurance carrier, the insurance provider Subscriber Member's name, your Emergency contact information for your student (we will also list our dorm resident parent as an emergency contact), and finally, you as the parent/guardian will need to **sign at the bottom of this page**.

All forms need to be completed in English and returned before your student is eligible to participate in Wisconsin organized athletic programs (sports) at Ladysmith High School.

Thank you for helping to make your student's American experience more rewarding and fulfilling.

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP / (/)	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 		
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 		
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

Cleared without restriction Cleared, with the following qualifications: _____

Not cleared Pending further evaluation For all sports For certain sports: _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type) _____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/APNP*: _____

Clinic Name _____

Address/Clinic _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

* Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

Subscriber Member Name (Primary Insured) _____

Emergency Information

Allergies _____

Other Information (medication, etc.) _____

Immunizations Up to date (see attached documentation) Not up to date - specify _____

(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.
2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____