



## Welcome to Pediatrics Plus Summer Program at Camp Aldersgate!

We are so excited to announce that Pediatrics Plus is partnering with Camp Aldersgate to offer a summer program this year. Pediatrics Plus Summer Program at Camp Aldersgate (“Summer Program”) is a Medicaid Early Intervention Day Treatment (“EIDT”) program. Children enrolled receive a variety of services including instruction in areas of cognition, communication, social/emotional, motor, and adaptive skills, nursing services, speech therapy, occupational therapy, and physical therapy. An individualized treatment plan (“ITP”) is created for each child based on the child’s specific needs. Your child’s specific goals and objectives will be worked on during camp activities throughout the day as well as during individual therapy sessions.

### Program Requirements:

1. Child has to be a Medicaid (Part A, TEFRA, waiver, or SSI) recipient
2. Child has to have an Autism Spectrum Disorder diagnoses (as defined in DDS Policy 1035)
3. Child has to qualify in 2 of 3 areas (Speech Therapy, Occupational Therapy, and Physical Therapy)

### Steps to Enrollment:

1. Contact your child’s primary care physician (“PCP”) regarding your interest in the Summer Program in order to let them know we will be sending evaluation prescriptions.
2. Return the attached Referral Packet along with copies of your child’s current evaluations for Occupational Therapy, Physical Therapy, and Speech Therapy to Pediatrics Plus. If your child is 10 years old and receiving Speech Therapy, a copy of your child’s IQ test is also required. Once this packet is received, your child will be placed on the waiting list. Children will be enrolled on a first come, first served basis; therefore, early enrollment is encouraged. You may return the Referral Packet:
  - To any Pediatrics Plus location;
  - By mail to 800 Exchange Avenue, Ste. 202, Conway, AR 72032;
  - By fax to 501.358.6264; or
  - By email to [bbeechler@pediatricsplus.com](mailto:bbeechler@pediatricsplus.com).
3. Once the Referral Packet is received, Pediatrics Plus will review the documents to ensure your child’s evaluations are current. If your child’s current evaluations do not meet the required guidelines, Pediatrics Plus will send a request to your child’s PCP for an evaluation prescription.
4. Once the signed evaluation prescription is received from the PCP, someone will contact you to set up your child’s initial evaluations (Psychological, ST, OT and PT) if needed.
5. After the evaluations are completed or approved upon review of the Enrollment Packet, an ITP appointment will be set up with our Summer Program Staff if your child meets all other program requirements for the summer program. The ITP appointment includes a brief meeting and medical evaluation that the parents and the child must attend.
6. After the ITP, the EIDT and treatment prescriptions are sent to your child’s PCP.
7. Once the signed EIDT and treatment prescriptions are received, you will be contacted with additional information about the Summer Program.

Please feel free to contact us with any questions or concerns you may have. Thank you for giving us the opportunity to serve you and your family!



## Pediatrics Plus Summer Program at Camp Aldersgate



Pediatrics Plus Summer Program at Camp Aldersgate operates 6 weeks during June and July to provide the continuity and engagement that help children with autism thrive during the summer months. Each child's unique strengths and interests are celebrated and incorporated in the daily discoveries and interactions in our sensory-rich and adventurous Camp Aldersgate location. Campers participate in camp with their typically developing peers, giving them the opportunity to grow and develop their social interaction, communication, and play skills. Our peers on the other hand, take great pride in participating at camp as role models, while learning how to accept, include, and help children with different abilities. Pediatrics Plus Summer Program at Camp Aldersgate is a summer experience all about love, hope, and acceptance! Action Camp serves elementary school aged children who have completed K-5th grades. Each Action Camp tribe includes up to 8-10 children with autism and 3 integrated play buddies. Adventure Camp serves children who have at least completed 6th grade. Adventure Camp includes a maximum of 10 campers per tribe with autism and a minimum of 3 peer volunteers. A 1:3 counselor to child ratio is maintained in each camp. All campers participate in a stimulating, developmentally appropriate, and fun program that includes exploration, creation, adventure, music, the arts, movement and fitness, and water play. Your child's age will determine their eligibility for Action Camp vs. Adventure Camp and as always, camper slots will be filled on a first-come, first-serve basis.

### ACTION CAMP ENROLLMENT

Action Camp serves **elementary children who have completed K-5th grade** with autism spectrum disorders and their typically developing peers. Each week includes lots of multi-sensory experiences that encourage our campers to build memorable relationships as well as explore new & exciting recreational fun! Daily schedules will include camp traditions, crafts and activities, and loads of outdoor play! Campers must sign up for all 6 weeks of camp, whether they attend or not. A 1-week break has been inserted to allow families to schedule vacations and staff to recharge.

**Required Summer Sessions For 2019:** June 10 – June 28 and July 8 – July 26

**Weekly Hours Required This Summer:** Mondays through Fridays from 8:30am to 1:30pm. Campers' slots will be filled as completed applications are received.

**2019 Action Camp Tuition:** Early Intervention Day Treatment Program billing through Arkansas Medicaid or Private Payment of \$2,400.00.

### ADVENTURE CAMP ENROLLMENT

Adventure Camp serves **middle school aged kids who have at least completed 6th grade** with autism spectrum disorders. Sport activities will take place each day to develop sportsmanship and team cooperation while allowing each Adventure Camper to play on their individual level and progress each week. Our campers will trek on the edge for some zip-lining fun, take a dip in the pool, and power up for archery. They will work each week managing a camp store to strengthen social skills and responsibility while having a truly wild time. Campers must sign up for all 6 weeks of camp, whether they attend or not. A 1-week break has been inserted to allow families to schedule vacations and staff to recharge.

**Required Summer Sessions For 2019:** June 10 – June 28 and July 8 – July 26

**Weekly Hours Required This Summer:** Mondays through Fridays from 8:30am to 1:30pm. Campers' slots will be filled as completed applications are received.

**2019 Adventure Camp Tuition:** Early Intervention Day Treatment Program billing through Arkansas Medicaid or Private Payment of \$2,400.00.



# Pediatrics Plus Summer Program at Camp Aldersgate



## CAMPER APPLICATION

Date of this application: \_\_\_/\_\_\_/\_\_\_\_\_

Did your child previously participate in A-Camp? (circle) Yes No If yes, what was the last year attended? \_\_\_\_\_

## CAMPER INFORMATION

Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_\_\_  
Last First Middle

Gender: (circle) male female Tshirt Size: \_\_\_\_\_

Where is your child's primary residence? \_\_\_with both parents \_\_\_with mother \_\_\_with father \_\_\_with guardian

Name of Primary Care Physician: \_\_\_\_\_ Physician's office phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Medical Diagnosis/Condition (if not applicable write "none"): \_\_\_\_\_

List any Secondary Diagnoses/Conditions: \_\_\_\_\_

How did you hear about Pediatrics Plus Summer Program at Camp Aldersgate? \_\_\_\_\_

If possible, this applicant would like to be assigned with the following cabinmate(s): \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

### Mother or Guardian

Check if custodial parent

Name: \_\_\_\_\_  
Last First

Relationship to camper: \_\_\_\_\_

Telephone Numbers: Primary \_\_\_/\_\_\_/\_\_\_\_ Secondary \_\_\_/\_\_\_/\_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

### Father or Guardian

Check if custodial parent

Name: \_\_\_\_\_  
Last First

Relationship to camper: \_\_\_\_\_

Telephone Numbers: Primary \_\_\_/\_\_\_/\_\_\_\_ Secondary \_\_\_/\_\_\_/\_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Who will be the primary contact while your child is at camp? (circle) *Mother* *Father* *other* \_\_\_\_\_

Best phone number to call: \_\_\_\_\_

If unable to reach parent/guardian, please notify: (Two different individuals not living in the same household are required.)

1) Full Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Primary telephone: \_\_\_\_\_ Secondary telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

2) Full Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Primary telephone: \_\_\_\_\_ Secondary telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

## PARENT/GUARDIAN AUTHORIZATION

*The following authorization MUST be signed before applicant can be accepted as a camper.*

The health history I have provided in this application is correct and complete as far as I know. I agree to inform Pediatrics Plus and Camp Aldersgate of any significant health related issues that may arise following submission of this application and prior to my child's/ward's participation in Pediatrics Plus Summer Program at Camp Aldersgate and understand additional information and/or physician authorization may be requested.

Pediatrics Plus Summer Program at Camp Aldersgate may not be able to accommodate all medical conditions and/or disabilities. Pediatrics Plus Summer Program at Camp Aldersgate reserves the right to make the final decision regarding admittance and dismissal of participants to its programs. This policy is to insure that adequate provisions can be made for participants while they are in the care of the camp.

Pediatrics Plus Summer Program at Camp Aldersgate serves those who do not require personal caregivers other than camp staff or engage in aggressive and/or abusive behavior. Campers are recruited on a non-discriminatory basis, without regard to race, color, creed, sex, national origin, religious or political affiliation.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## INSURANCE INFORMATION

### Primary Funding Information

Company Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Member ID or Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Secondary Funding Information (if applicable)

Company Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Member ID or Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PERSONAL CARE AND ACTIVITY INFORMATION

The following specific applicant information is to be completed by parent/guardian for camp medical staff. A copy will be given to the applicant's counselors. Please attach any additional information necessary to assist the counselors and volunteers to care for your child.

Does the camper like to be called by any other name? \_\_\_\_\_ Age during camp: \_\_\_\_\_

Current grade in school: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: (circle) male female

Please indicate (√) the level of assistance needed for the following daily activities

Personal Care Activity	needs no assistance	minimal assistance	total assistance	notes/needs	
brushing teeth					
showering					
dressing					
hair brushing					
transfer (to and from wheelchair)					
Camp Activity	needs no assistance	minimal assistance	total assistance	should not participate	notes/needs
swimming					
SCUBA					
fishing					
canoeing/boating					
outdoor sports and games					
archery					
adventure challenge activities (ropes course)					
nature trails					
arts/crafts					

Please circle/write the appropriate information below (attach additional page if needed)

Ambulation: wheelchair: <i>manual</i> <i>electric</i> walker crutches braces walks alone - no devices wanders? yes no occasionally
Sleeping: no problems needs help turning over needs help getting in or out of bed needs bed rails wets bed wears diapers at night walks in sleep usual sleep time: from _____ p.m. to _____ a.m.
Behavior: no problems use time out (minutes: _____) problems triggered by: _____ positive reinforcers: _____ suggestions: _____
Toilet Management: no problems diapers training pants catheterization every _____ hours self-catheterization catheter size _____ brand _____ type _____ usually has bowel movement every _____ day(s) needs help with: _____
What does the applicant take for pain/discomfort: _____

Eating: no assistance needed at meals regular diet G-Tube NG-Tube tube feedings every _____ hours food must be: cut chopped mashed pureed must be fed special utensils: _____ needs help with: _____ special diet: _____
Seizures: none has seizures date of last one _____ Type _____ usual duration _____ usual frequency _____ triggered by _____
Communication: no problems non-verbal sign language limited abilities can communicate personal care needs communication device (type _____)
Hearing: no problems oral deaf hearing impaired wears aides
Vision: normal wears glasses limited blind
Heat Tolerance: good fair poor

## SPECIAL INSTRUCTIONS AND DAILY ROUTINES

*Pediatrics Plus Summer Program at Camp Aldersgate strives to make each camper's participation a safe, comfortable, and fun experience. It is important that we have as much information as possible regarding what your child is used to and comfortable with. Sometimes following routines or special ways of doing things helps a camper feel more at ease with a new environment. Please take a few moments and share with us your child's typical daily routine (especially consistent behavior problems, as well as personal care and mealtime procedures) and include any special instructions, techniques of motivating and rewarding your child, hobbies, likes/dislikes, etc. Everything that you provide will help us better care for your child. (example: My child will only settle down at night if I rock her. She will smile each morning if I hum a song to her.) Also include any goals you would like the applicant to achieve during their stay at camp.(examples: improve personal care skills, make new friends, learn to float in pool, etc.) Enclose extra pages if necessary.*

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### IMMUNIZATION HISTORY

We are required to have a copy of each camper's immunization record on file.

**New campers** - a **complete** copy of his/her immunization record **MUST** accompany this application.

**Returning campers** - all we need is a record of any immunizations received since your last participation in activities at Camp Aldersgate. If your child has not received any new immunizations, disregard this section.

Applications submitted without the required immunization information cannot be processed until this information is received. Pediatrics Plus Summer Program at Camp Aldersgate adheres to immunization guidelines used by most educational facilities. ***Please check with your school nurse or administration about obtaining a copy of your child's record.***

## OPTIONAL INFORMATION

*The following section is information used solely for gathering statistical information and obtaining grant funding. Omission of any or all questions will not affect the status of your child's application or eligibility for participation in the Summer Program. Answer questions as they pertain to your child and his/her household.*

Ethnic Origin: (circle one)   Black/African American   Asian   White   American Indian   Hispanic/Latino   Other: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

Household Information: (circle one)   two parent   one parent

Number of Children, not including camper, living in household: \_\_\_\_\_

Household Annual Income: (circle one)   less than \$25,000   \$25,001-\$35,000   \$35,001-\$50,000  
\$50,001-\$75,000   \$75,001-\$100,000   \$100,001+

Camper Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## HEALTH HISTORY AND PHYSICIAN'S AUTHORIZATION

*The Health History and Physician's Authorization (both sides of this form) is to be completed by the applicant's Primary Care Physician. It will be used by the camp's medical staff to determine medical eligibility, be reviewed by the camper's counselors, and will be kept on file in the infirmary.*

Dear Physician,

Pediatrics Plus Summer Program at Camp Aldersgate is an Early Intervention Day Treatment summer program for children with medical conditions, physical disabilities, and developmental delays. Activities for Pediatrics Plus Summer Program at Camp Aldersgate may include nature hikes, canoeing, fishing, swimming, SCUBA, archery, campfires, music, adventure/challenge (ropes course) activities, arts and crafts. Although activities have been adapted so children of all abilities can participate, they may require physical exertion and/or travel to and from various locations throughout the camp.

Please complete both sides of this form. Attach additional information you feel the camp medical staff should be aware of.

Primary Medical Diagnosis:(if not applicable write "none") \_\_\_\_\_

List any Secondary Diagnoses: \_\_\_\_\_

CURRENT MEDICATION(S) (please indicate if pill, inhaler, injection, etc.)	STRENGTH	DOSAGE	TIME(S)			
			breakfast	lunch	dinner	other

## ALLERGY INFORMATION

Is this child allergic to any:

Medications	Name	Reaction (be specific)	Age of last reaction
Foods	Name	Reaction (be specific)	Age of last reaction
Animals	Name	Reaction (be specific)	Age of last reaction
Insects			
Plants			
Other	Name	Reaction (be specific)	Age of last reaction

Is this child latex sensitive?      yes      no

Camper Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

height: \_\_\_\_\_

weight: \_\_\_\_\_

blood pressure: \_\_\_\_\_/\_\_\_\_\_

heart rate: \_\_\_\_\_

respiration rate: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Body System	normal	abnormal	If abnormal, please explain
HEENT			
Cardiovascular			
Respiratory			
Gastrointestinal			
Skeleto-muscular			
Genitourinary			
Other – please explain			

Please circle/write the appropriate information below

General: frequent ear infections heart defect/disease seizures bleeding/clotting disorders hypertension rashes/ringworm

comments regarding circled items: \_\_\_\_\_

Surgeries (specify): \_\_\_\_\_

Childhood Diseases: chicken pox mumps measles german measles other (specify): \_\_\_\_\_

For Female Applicants - Has this applicant menstruated? yes no If so, is her menstrual history normal? yes no

Special consideration: \_\_\_\_\_

**Medical Equipment**

wheelchair charger hearing aids dialysis cyclor other: \_\_\_\_\_

Bi-PAP C-PAP ventilator inhaler hospital bed other: \_\_\_\_\_

Has Down syndrome been diagnosed in this applicant? yes no

If yes, is the applicant clear of Atlantoaxial Dislocation Condition confirmed by diagnostic x-ray? yes no

Restrictions/limitations on participation in any camp activities: \_\_\_\_\_

Additional Comments:

**PHYSICIAN'S AUTHORIZATION**

I have examined \_\_\_\_\_ within the past 6 months (date examined: \_\_\_\_\_) and in my opinion, his/her condition **DOES NOT** preclude his/her participation in an active camp program.

Physician's Printed Name: \_\_\_\_\_ Phone: / \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Licensed Physician Signature (or Advanced Practice Nurse/Registered Nurse Practitioner representing the physician):**

**X** \_\_\_\_\_ Date: \_\_\_\_\_



## MEDICAL AND SOCIAL HISTORY

### **Patient's Birth History (please be as thorough as possible)**

Child was born at \_\_\_\_\_ weeks. Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ ozs.

Please describe any medical problems during pregnancy: \_\_\_\_\_

Child's Health at birth (NICU, Oxygen, any other complications): \_\_\_\_\_

### **General Developmental and Social History:** *Please list the age at which your child has met the following developmental milestones, if applicable:*

Babble (use of consonants): \_\_\_\_\_

Single word use: \_\_\_\_\_ How many? \_\_\_\_\_

Sit w/o support: \_\_\_\_\_

Crawl: \_\_\_\_\_

Pull to Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Finger Fed: \_\_\_\_\_

Potty Trained: \_\_\_\_\_

Can child follow simple daily instructions? \_\_\_\_\_

Does your child attend: School Daycare Both

If so, please list name of school and/or daycare: \_\_\_\_\_

If your child is in school, what type of classroom is he/she in? \_\_\_\_\_

### **Family Medical History**

Please list others living in the same household:

Name:

Relationship to patient:

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Has anyone in the child's family ever had any of the following? (Please mark which family member in the corresponding box):

	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand-mother</b> (indicate M for maternal and P for paternal)	<b>Grand-father</b> (indicate M for maternal and P for paternal)	<b>Extended Family</b> (aunt, uncle, cousin, etc.)
Attention/ADHD Problems						
Speech Problems						
Motor/Vocal Tics						
Depression						
Anxiety						
Bipolar						
Schizophrenia						
Learning Disability						
Sickle Cell Disease						
Seizure Disorder						
Alcoholism						
Drug Abuse						
High Blood Pressure						
Lung Problems/Asthma						
Heart Problems						
Behavior Problems (please specify):						
Other (please specify):						

What are your primary concerns about your child? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of School your child currently Attends: \_\_\_\_\_

I, the undersigned, certify that I have provided accurate information and answered all questions on this form truthfully to the best of my knowledge. I authorize Pediatrics Plus to release any information including the diagnosis and the records of any treatment and examination or any other personal health information rendered to my child to custodial parents and/or legal guardians, Camp Aldersgate, third party payers, health practitioners, my attorney(s), and/or any other person or institution to whom I have given a separate Release for Medical Information, as necessary. I authorize and request my insurance company to pay directly to Pediatrics Plus benefits otherwise payable to me.

I understand that it is my responsibility to keep Pediatrics Plus informed of any change in the above information.

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent/Guardian Printed Name

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

**I authorize PEDIATRICS PLUS**

to disclose my health information to \_\_\_\_\_ Primary Care Physician  
(Name of Physician, clinic, hospital, self, etc)

and I authorize the Covered Entity \_\_\_\_\_ Primary Care Physician  
(Name of Physician, clinic, hospital, self, etc)

to disclose my health information to PEDIATRICS PLUS.

**Purpose of use, disclosure, or request:**  Continuity of care & treatment;  At the request of the patient;

Payment;  Medical history;  Other issues (specify)

**Information to be used and/or disclosed:**

Clinical (Example: History & testing; therapist reports; EI treatment plan; clinic treatment plans)

Other (specify) \_\_\_\_\_

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol or drug abuse; psychiatric or mental illness; domestic violence; child abuse; incarceration; legal difficulties; and/ or sexually transmitted diseases, including HIV or AIDS virus.

This authorization will expire upon termination unless you specify a different expiration date, event or condition:  
Please specify: \_\_\_\_\_

**I understand that I have a right to revoke this authorization at any time except to the extent that the release of information has already occurred in reliance on my prior authorization.**

**I understand that to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to Pediatrics Plus. The revocation document is to contain the signature of the patient or patient's legal representative.**

**I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.**

**I understand that any disclosure carries with it the potential for re-disclosure by the recipient of this information and such re-disclosure may not be protected by federal confidentiality laws.**

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Parent/Guardian Printed Name

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

**I authorize PEDIATRICS PLUS**

to disclose my health information to: Camp Aldersgate, Inc.  
(Name of Physician, clinic, hospital, self, etc)

**and I authorize the Covered Entity** Camp Aldersgate, Inc.  
(Name of Physician, clinic, hospital, self, etc)

to disclose my health information to PEDIATRICS PLUS.

**Purpose of use, disclosure, or request:**  Continuity of care & treatment;  At the request of the patient;

Payment;  Medical history;  Other issues (specify)

**Information to be used and/or disclosed:**

Clinical (Example: History & testing; therapist reports; EI treatment plan; clinic treatment plans)

Other (specify) \_\_\_\_\_

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol or drug abuse; psychiatric or mental illness; domestic violence; child abuse; incarceration; legal difficulties; and/ or sexually transmitted diseases, including HIV or AIDS virus.

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**I understand that any disclosure carries with it the potential for re-disclosure by the recipient of this information and such re-disclosure may not be protected by federal confidentiality laws.**

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Parent/Guardian Printed Name