

Warren Glen Academy
2024-2025 School Year

Dear Parent(s)/Legal Guardian(s):

Warren Glen Academy requires a parent/guardian of a student who is absent to **notify the school of the absence**. Please do so by **notifying the school nurse** who will document the absence. I, the school nurse, will be calling the parent/guardian of an absent student if I do not receive a phone call notifying me of the absence. When calling, if you do not speak directly to me, please leave your child's name and date of the absence. I would appreciate also if you would leave a reason for the absence. By doing so, I am able to see if there is a trend of a type of illness that is going around the school. If you are kind enough to leave me a reason for the absence, it will be documented as such.

Please note that for your convenience, you may leave me a message regarding an absence or any other medical issue on my voice mail at any time. You do not need to wait until school opens in the morning to do so, especially if you need to leave for work early. Any messages left are confidential and only I can retrieve them. When you call the school number and a recording begins, you may press #3 or extension 109 to reach my office. You do not need to listen to the complete message before doing so. Please remember to report absences to me since I am the person who calls to confirm absences if I do **NOT** receive a message. I will be glad to inform your child's teacher that you notified the school. If you know in advance that your child will be absent for an appointment, etc., you may call ahead and inform me. I will note it on my calendar, and you will not need to recall the day of the appointment.

If your child is seen by a physician, remember to ask for an excuse from school so that I can file the note in your child's medical file. Often school districts ask to see a student's attendance record, if I have any physician notes available, I make the school district aware. **Physician's note is required to return to school if absent three or more days.**

A few reminders:

Please keep me updated regarding **any medication changes** made throughout the year for your child, even if I do not administer the medication in school. This permits me to better assess a child if they come to the health office with symptoms that may be attributed to a side effect of a new medication. It also allows me to have current information in case of an emergency and the need arises that your child is sent to the hospital. It is important that the hospital is aware of medications taken. Even though you will be notified immediately of your child's need to go to the hospital, often with this information the medical personnel can begin to evaluate your child immediately.

***It is extremely important to contact the school with any change in address or phone numbers. If you have a cell phone available, please notify us of the number, and also try to include an emergency contact person that is available during the day at the home or cell phone number that you provide for them.

Some students **will require a physical examination to attend school this year**. Physicals are annually up until 4th grade (your grade 4 physical will be good through 6th grade) then one will be needed for grades 7-9, and then another one for grades 10-12. Please have the physical examination form completed and returned to school before or no later than the month of **September**, along with updated vaccinations. It is always helpful to have current medical information in a student's medical file.

As always, thank you for your cooperation. If you have any questions or concerns now or throughout the school year, please feel free to contact me at 908-995-1999, ext. 109. If I am not available, please leave me a message and I will return your call.

Thank you,

School Nurse



Dear Parent/Guardian of students who receive routine medication in school:

Please note that ALL medications are to be brought to the school in the original medication container dispensed by the pharmacy. State regulations require that all medications be dispensed from a pharmacy bottle. The correct dose must be printed on the label.

In order, for the medication to be administered at school, the nurse must also have a written doctors order. If the medication dose changes during the year, we must also have a current order for that change. Your child's physician may **fax** the order directly to Warren Glen Academy: **908-995-1994**. The medication must be brought to school by a parent/guardian or given to the bus driver, who in turn will deliver it to a staff member. The children are not allowed to carry/bring the medication to school. We regret any inconvenience this may cause you.

When your child has a few days' supply left at school, I will call or send a note home requesting a new supply. If you need the labeled bottle, please let me know. When returning a medication supply, please notify me of the quantity of pills dispensed if it differs from the existing pharmacy label.

Any questions or concerns please contact me at school, 908-995-1999, extension 109.

Thank you,

School Nurse



Dear Parent/Guardian,

Each year we are mandated by the state to give a variety of health screenings which include vision, hearing, blood pressure, weight and scoliosis to all our students providing for their beneficial health and wellness as they develop and grow.

Students in grades K through 3 are screened annually.

In grades 6 – 8 and grades 9 – 12 students are screened once per year.

Vision screening is mandated in grades 1 through 3, grade 6, 8 and 10.

Hearing screening is mandated in grades 1 through 3, and grade 7.

A Scoliosis check is typically done in the spring and is mandated for ages 10 through 18.

For the scoliosis check our school nurse will send a letter home to inform you as to when scoliosis check will be administered.

Although parental/guardian permission is not required for these screenings, we feel it necessary to give our parents and guardians notice that these screenings will commence in January.

Thank you for your understanding as we support the health and wellness of your child.

A handwritten signature in black ink, appearing to read "Fran Corl".

Fran Corl – Executive Director, Warren Glen Academy

Cc: Joan Holland – School Nurse



Dear Parent/Guardian:

Attached please find the medication forms that you may need for your child. For medication to be administered in the school setting, a physician order in addition to parental permission needs to be on file. Please review the attached forms and contact me if you have any questions or concerns. I can be reached at 908-995-1999 ex 109. The following is a brief explanation of the attached forms.

- 1. PRN medication form-** If you would like your child to be given Acetaminophen (Tylenol), Ibuprofen (Motrin, Advil), Benadryl, or Tums as needed, please complete this form. Our school physician has given a standing order for these medications; however, I also need parental consent to administer these medications.
- 2. Medication/Doctor's Order to dispense form-** This form is to be used for any **routine medication** order (medication that is administered each day) or **any other PRN** (as needed) medications besides the medications listed on our standing order form. The physician completes the top half and the parent completes the bottom portion. Both sections need to be completed in order to administer the medication in school.
- 3.** If your child has asthma and uses an inhaler, please have their physician complete the **Asthma Action Plan** form. As the parent, please be sure to also sign the form which gives consent for the use of the inhaler.
- 4.** The form known as the **Permission for Self-Administration of Medication** form is required if you would like your child to be able to carry their epi-pen or inhaler. This is extremely useful especially during a field trip when students are in various groups throughout the area. Inhalers and epi-pens are held in the health office while in school usually kept by the school nurse who accompanies the students on a field trip.
- 5. The Allergy Form: If your child has the type of allergy which may require treatment (example, antihistamine or epi-pen) an allergy form must be completed by his/her doctor.**
- 6. ****Please note that if your child required more than one medication to be administered in school, a separate medication form must be completed for each medication. If you need additional copies, please feel free to call the school.**
- 7.** If you have any questions regarding these forms, please feel free to contact me. You may leave a voicemail message with a return phone number for me to contact you. (My voicemail is confidential, my substitute being the only other person having access). During the summer months, my hours may vary. I will return your call as soon as possible. If, the issue is urgent, you may leave a message with a substitute nurse or the school secretary.

Warren Glen Academy
PERMISSION FOR ADMINISTRATION OF MEDICATION*

*To be accompanied by "Medication/Doctor's Order to Dispense" **or**
"Order for Pre-filled, Single Dose Autoinjector Mechanism containing Epinephrine"

A pupil may be permitted to self-administer medication for asthma, allergic reaction to insect stings or other potentially life-threatening illness. The parent/guardian must present written authorization for the self-administration of the medication.

The child's physician must certify in writing that the child has asthma or another life-threatening illness and that the child is capable of and has been instructed in the administration of the prescribed medication.

The parents/guardians must sign a statement acknowledging that Warren Glen Academy employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil, and that the parents/guardians shall indemnify and hold harmless the school and its employees or agents against any claims arising out of the self-administration of this medication by the pupil.

Your child's medication will be kept in the Health Office and provided as needed per M.D. directive. Please complete form with physician and return to the school nurse.

This permission must be renewed annually.

I request that my child _____, be provided with the medication stored in the Health Office: _____. I realize that Warren Glen Academy School, its employees or agents, shall incur no liability as a result of any condition or injury arising out of the self-administration of medication.

Parent/Guardian signature

Date

Physician please complete the following:

I certify that _____ has the following life-threatening condition
(Student Name)
_____ and that he/she is capable of and has been instructed in the proper self-administration of the following medication: (ex. Ventolin)

Printed Name of Physician

Physician's Signature

Address

Phone

Date

Director's Signature

Date



WARREN GLEN
ACADEMY

Student Health Questionnaire

It is very important that your child's school health records remain up to date. Please fill out this form with health information that would benefit the nurse or teacher in caring for your child.

Students Name: _____

_____ My child does not have any significant health problems currently.

****List all current Medical Diagnosis _____

Please be aware of: (please give dates)

Recent surgery _____

Serious injury or illness _____

Allergies: (include all allergies) _____

Recent boosters _____

****Please have physician's office send the confirmation of booster(s)\ Immunizations to the school. Attention: school nurse

Vision corrections: Wears glasses _____ Wears contacts _____ None _____

Hearing problems _____ Seizures _____ Asthma _____ Heart disease _____ Hepatitis _____ Diabetes _____

Is your child taking medication currently? Yes _____ No _____

If so, please list **ALL** medications taken including AM and PM doses taken before and after school. List the name of medication, dosage and time taken. For medications to be administered in school **PLEASE ATTACH PHYSICIAN ORDER.**

Physician's name & Phone number _____

Psychiatrist's name & Phone number _____

Parent/Guardian's Signature _____ Date _____

Warren Glen Academy
Allergy Action Plan (food or insect)

Student's Name: _____ D.O.B. _____

Allergy to: _____

Asthmatic: YES* NO *Higher risk for severe reaction

Step 1 Treatment

Symptoms:

If your child has any symptoms of an allergic reaction of any kind, Warren Glen Academy has standing orders from our school doctor to give Benadryl for a mild reaction, such as a rash or mild itching. If symptoms worse such as, severe hives/rash, swelling in the face and or tongue, nausea/vomiting/abdominal cramps, tightness in throat or trouble breathing, low blood pressure/fainting or pulse that is hard to feel, trained staff will administer an Epi-Pen appropriate for your child's age.

The severity of symptoms can quickly change. *Potentially life-threatening. By law we are to have on hand, two different Epi-pens. Epi-pen Jr. is for children who are under 66lbs., and the other is for anyone over 66lbs.

Epinephrine: Inject intramuscularly per child's weight/per our school doctor's standing orders.

Antihistamine: Benadryl will be given per our school doctor's standing orders.

If you want a different antihistamine used, the school nurse will need a doctor's order and medication brought in by parent.

Other Antihistamine: _____

Medication/dose/route

Step 2: Emergency Calls to 911 and Parent/Guardian

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency Contacts:

Name/relationship	Phone Numbers	
_____	1) _____	2) _____
_____	1) _____	2) _____
_____	1) _____	2) _____

Even if Parent/Guardian cannot be reached, do not hesitate to medicate or take child to Medical Facility

Parent/Guardian Signature _____ DATE _____

Doctor's Signature: _____ DATE _____



School year 2024-2025

Dear Parent(s):

Re: Scoliosis Screening

Scoliosis is a lateral curvature of the spine most commonly detected during the adolescent growth period. It is estimated that between 5% and 10% of school children have such a curvature to varying degrees. However, only about 2% of these curvatures are significant. If someone else in the family has scoliosis, the likelihood of incidence is much higher- approximately 20%. The effect of scoliosis depends upon its severity, an its early detection and treatment.

Scoliosis screening is performed every two years between the ages of 10 and 18. The goal of this mass screening program is early identification, because curvatures can often be controlled if detected early. Students diagnosed with scoliosis should be under the care and supervision of a family healthcare provider or clinic. Referral to an orthopedist or orthopedic clinic may also be indicated.

Kindly complete this form and return to me. Scoliosis screening will be part of the yearly health screening to begin in September.

Thank you,

School Nurse

I understand my child will be screened for scoliosis in the 2024/2025 school year.

My child is currently being followed by his/her physician for this screening or for treatment of this condition.

Physician name and phone number _____

Please do not perform this screening on my child.

** Please note that if this form is not returned, your child will be screened for scoliosis.

Signature of parent _____

Date _____

PARENTAL CONSENT TO SHARE HEALTH INFORMATION

Dear Parents/Guardians:

The laws regarding confidentiality and health information have become increasingly stringent. In order to ensure that your child's health needs are adequately met in school, it is important to share information with the teachers who are directly involved with your child. Before this information may be shared, we must have your written consent. Written/verbal information regarding your child's condition, symptoms to watch for, and action to take if a problem arises will be provided to the teachers indicated. If you do not want information shared with anyone on this list, please INITIAL the line that indicates this, and sign and date the bottom of this page. If you would like information to be shared with school staff, INITIAL next to each member that you are giving permission. This consent will be effective for the school year of July 2024-July 2025. You may waive this consent at any time by indicating this change in writing.

Student Name: _____ Birth date: _____

List health concerns: _____

Initial which staff members are permitted to have medical information about your child (substitutes will be given information on an "As needed" basis if covering for a staff member that you have granted permission)

Initial which staff members are permitted to have medical information about your child (substitutes will be given information on an "As needed" basis if covering for a staff member that you have granted permission.

- Level I teacher and classroom aide
- Level II teacher and classroom aide
- Level III teacher and classroom aide
- Level IV teacher and classroom aide
- Administration
- Reflection Room Staff
- Speech Teacher
- Art Teacher
- Tech Ed Teacher
- Other (please indicate) _____

I give my consent for the school nurse to provide the staff members indicated above written/verbal information regarding the management of health concerns for my child.

____ Initial if you do NOT want your child's information shared with any staff members.

Parent/Guardian signature: _____ INITIALS _____ Date: _____

**** You must INITIAL for this form to be valid. Check mark will not be accepted. ****



2024-2025 School Year

Dear Parent/Guardian:

As per Board Policy #5330, we are informing you of the following information pertaining to the administration of medication, specifically in the use of a pre-filled auto-injector mechanism (also known as an Epi-Pen).

Our School Nurse, as well as staff members have been trained in the use of an auto-injector. The school and its employees shall have no liability as a result of any injury to a student arising from the administration of epinephrine via a pre-filled auto-injector mechanism.

Sincerely,

Dr. Randy Pratt
Executive Director

____ I understand that the Warren Glen Academy shall incur no liability as a result of any injury arising from the administration of epinephrine via a pre-filled auto-injector mechanism to the student and the parent shall indemnify and hold harmless the school and its employees or agents against any claims arising out of the administration of epinephrine via a pre-filled auto-injector mechanism to the student.

Print Name of Student

Signature of Parent

Date



**WARREN GLEN
ACADEMY**

2024-2025 SCHOOL YEAR

Dear Parent/Guardian:

Please read, sign and return to school. Any questions or concerns please feel free to contact the school nurse.

RE: Protocol for any suspected illness or rash that may be contagious.

It is at the discretion of the school nurse and school policy to determine if an illness or rash may be contagious. If the school nurse using her medical knowledge feels that a condition may jeopardize the health of other students, she will contact the student's parent or guardian and request that they come to school to take the child home. Depending on the physician's diagnosis, a minimum period of 24 hours of treatment is needed before returning to school with longer periods of time needed for some conditions. The child must present a physician's note stating the date the child may return to school and the treatment prescribed.

Upon receiving this note, the child will be allowed to return to school. In certain circumstances, the child may be asked to keep the area covered while in school, such as a rash, to protect the other students.

Some common conditions that you may receive a call to come pick up your child are as follows but not limited to:

Chicken Pox (Varicella)
Conjunctivitis (Pink Eye)
Impetigo
Measles
Mumps
Fifth's disease (rash with fever)
Poisons (such as poison ivy, oak, sumac)
Ringworm
Rubella (German Measles)
Scabies
Staph or Strep Infections

Parent Signature _____ Date: _____



**WARREN GLEN
ACADEMY**

There will be sunscreen and insect repellent available for your child to use during outdoor activities at school and on field trips. Please sign below to consent to the following to be used for your child:

COPPERTONE ULTRA GUARD SPF 50 (clear spray, no rub) or equivalent if above is not available.

I give permission for my child to use the above sunscreen.

Name of Child _____

Parent/Guardian Signature: _____ Date _____

Off insect repellent spray or equivalent if above is not available.

I give permission for my child to use the above insect repellent.

Name of Child _____

Parent/Guardian Signature: _____ Date _____

Warren Glen Academy

PRN MEDICATIONS

Our School Physician has written standing orders allowing the School Nurse to administer Acetaminophen (Tylenol) or Ibuprofen (Advil/Motrin) for fever or pain, Benadryl for allergic reaction and Tum (s) for GI discomfort, provided written permission is granted by the parent/guardian.

Please indicate your permission below, by signing for **EACH** medication separately that you are giving permission to administer as needed.

Student Name _____ Date of Birth _____

Allergies: _____

The School Nurse has my permission to administer the following:

Acetaminophen (Tylenol) Parent/Guardian signature _____

Ibuprofen (Advil/Motrin) Parent/Guardian signature _____

Benadryl Parent/Guardian signature _____

Tum Parent/Guardian signature _____

Parent/Guardian PRINT name _____ Date _____

***Please note, if your child will need any other medication beside the four medications listed above, you will need to obtain a Physician's order from your child's physician. Please request medication forms from the School Nurse if you do not already have one. Medication orders are only good for one school year and need to be renewed yearly.

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The immunization record must be attached for the form to be valid.

- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

g. **Behavioral/Mental Health Issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.

- For lead screening state if the blood sample was capillary or venous and the value of the test performed.
- For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
- Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)

- Print the health care provider's name.
- Stamp with health care site's name, address and phone number.

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last)		(First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier			
Parent/Guardian Name		Home Telephone Number () -		Work Telephone/Cell Phone Number () -	
Parent/Guardian Name		Home Telephone Number () -		Work Telephone/Cell Phone Number () -	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:			Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Abnormalities Noted:			Weight (must be taken within 30 days for WIC)		
			Height (must be taken within 30 days for WIC)		
			Head Circumference (if <2 Years)		
			Blood Pressure (if ≥3 Years)		
IMMUNIZATIONS			<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____		
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the signs/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					