Island View

ADMISSION RECORD

Identification Information									
Resident Last Name		First		Initial	Legal Status	Social Security Number			
Age	Birth Date	Birth Place		Sex		Race			
Resident Address		City/State			Zip	Home Phone			
Religion		Last School Attended			Type of Employment				
Parent/Guardian #1 Name		Telephone H:	M: W:			Birth Date			
Address		City/State			Zip	Email			
Parent/Guardian #2 Name		Telephone H:	M: W:			Birth Date			
Address		City/State			Zip	Email			
Emergency Contact (other than parent)		Emergency Phone		Relationship		Custody of Resident belongs to			

Financial Information									
Guarantor #1 Name		Telephone H:	W:			Social Security Number			
Address		City			State	Zip			
Guarantor's Employer		Work Address			City	Zip			
Insurance		Policy Number		Group		Telephone			
Guarantor #2 Name		Telephone H:	W:			Social Security Number			
Address		City			State	Zip			
Guarantor's Employer		Work Address			City	Zip			
Insurance		Policy Number		Group		Telephone			

Office Use Only					
Resident Number	Team Assigned	Therapist Assigned		Referral Source	
Date of Admit / Time	Arrival Mode	Readmission	Admitted by Whom	Attending Physician	

ISLAND VIEW
Residential Treatment Center

ENROLLMENT AGREEMENT

This agreement ("Agreement") is entered into by and between Island View Residential Treatment Center, L.L.C., a Delaware limited liability company, (hereinafter "Island View") *operating as* ***Island View,*** a licensed program which is described in the program materials that Sponsor has received previously and which is made a part of this Agreement by reference (the "Program") and _____, the parent(s) and/or guardian(s) of the Resident (hereinafter the "Sponsors"). Sponsors' address is: _____, and phone number is: _____.

In consideration of the mutual promises set forth in this Agreement, Island View and Sponsor (hereinafter the "Parties") mutually agree as follows:

1. **SPONSOR'S REPRESENTATIONS.** Sponsor warrants that Sponsor is the legal parent(s) and/or guardian(s), having legal custody, of the following child: _____ whose birth date is_____(hereinafter the "Resident"), and that Sponsor desires to and does hereby contract with Island View for the Resident's enrollment in the Program according to the terms and conditions of this Agreement. In entering into and performing under this Agreement, Island View is relying on all representations and promises of the Sponsor contained or expressed in this Agreement and all other documents and information sheets from Sponsor to Island View, and Sponsor expressly warrants the truth and accuracy of the same.

2. **TERM OF AGREEMENT/CUSTODY.** This Agreement shall commence on the day of enrollment which is: _____ and remain in effect until the child's discharge date. On the day of enrollment, Sponsor shall transfer, by a Power of Attorney in the form received and executed by Sponsor, temporary custody of the Resident to Island View for the duration of the enrollment period, or until the Resident attains the age of eighteen (18), unless the Resident (a) has otherwise been placed in the custody of Island View by a court of proper jurisdiction or (b) voluntarily consents in writing to remain in the Program for any period of time beyond said eighteenth (18th) birthday.

3. **PROGRAM COSTS AND PAYMENT TERMS.**
   A. PROGRAM FEES. The Resident is accepted with the expectation that the Resident will complete the individual master treatment program. The Program fee per month excludes the cost of psychotropic and other medications, laboratory fees, and medical services as may be necessary. Sponsor agrees to pay the regular daily rate and fees while the resident is on a Leave of Absence (LOA). Sponsor agrees to pay all attorney fees, court costs, filing fees, and charges of commissions that may be assessed by any collection agency retained to pursue collection of any outstanding sums.

   B. SCHEDULE AND METHOD OF PAYMENT OF PROGRAM FEES; LATE FEES.

   (1) At the time of admission, private pay sponsors shall pay 1) an initial payment of the first months' tuition which is pro-rated, 2) tuition deposit which includes the aftercare tuition and 3) admission fee. (For specific dollar amounts, please refer to the Financial Agreement). This initial payment may be paid by check.

   (2) All subsequent payments shall be paid by accepted credit card (VISA, Mastercard or American Express), checks, wire transfer or pre-authorized electronic check debits (ACH).

   (3) Sponsor shall also provide a valid credit card number with a credit capacity equal to two months' tuition at the time of admission. In the event that a subsequent tuition payment is not paid when due, Sponsor authorizes the program to charge the past due amount, including late fees, to the credit card number provided by the Sponsor at the time of enrollment.

   (4) Payments are due the 1st day of the month of service. For example, October tuition is due October 1st. Payments not received by the 1st of the month of service are subject to a $250 late fee and may result in discharge of the resident from the program. With the exception of the discharge summary, transcripts

and other transition information, such as resident records, will not be released after a resident discharges until all tuition and fees are paid in full.

(5) Residents with resident loans must provide a copy of an executed promissory note from the lending institution prior to enrollment. Actual funding must take place within ten days of enrollment. Residents receiving school district/mental health assistance must provide the program with written pre-approval from the district and county mental health before enrollment. Sponsor is responsible for payment of all tuition and fees not paid.

(6) The program is not in a position to absorb delinquent insurance balances. The program reserves the right to discharge residents whose insurance claims become delinquent. Upon decertification of the case by the insurance company, Sponsor shall pay the amount due. If the non-contracted insurance provider fails to pay within 60 days of submission of a claim, Sponsor shall pay the amount due. Sponsor will be timely refunded after the program receives payments.

C. FEE INCREASES. The current tuition fee is subject to increases upon 60-day notice.

D. EARLY WITHDRAWAL OF RESIDENT. If Sponsor or authorized third party withdraws Resident before treatment is completed as determined by the Island View treatment team, **Sponsor understands and agrees that Sponsor shall immediately (1) pay all outstanding account balances and tuition through the end of the month in which the Resident is withdrawn and (2) forfeit the tuition deposit.** The forfeiture of the tuition deposit reflects the recognition that certain costs associated with making the program available to the Resident are incurred, whether or not the program is completed, including such items as salaries, inventories, and other general operating expenses. Therefore, Sponsor understands and agrees that the policy of non-refundable payments and expenses is a reasonable estimate of the losses (i.e., Liquidated Damages) the program incurs with the early withdrawal of Resident. **If applicable, Sponsor shall be refunded any remaining tuition thereafter.**

E. ADDITIONAL COSTS AND EXPENSES. In addition to the Program fee, Sponsor agrees to pay for the following expenses of the Resident: transportation from the Resident's current residence to Syracuse, Utah, and return transportation to the Resident's current residence; food and lodging expenses for any holding period before commencement of the Program and/or after completion of the Program; all medical, dental, hospital, prescription medication, and related expenses incurred by or for the Resident, and all required personal items specified in the resident clothing list. Sponsors are also responsible for any additional escort fees required for transporting Resident to and/or from the Program to another location (i.e., airport, doctor's appointment or special event), outside the normal business hours (i.e. business hours are Monday-Saturday 9:00 am – 4:00 pm, with the exception of formal holidays).

F. PERSONAL INJURY AND DAMAGE TO PROPERTY. Sponsor agrees to accept full responsibility for (1) the repair or replacement of any property damaged, defaced, or destroyed by the Resident, whether owned, leased, or controlled by Island View or any third party, and (2) any personal injury to any Island View personnel, other residents or third parties caused, in whole or in part, by the Resident; and to promptly reimburse Island View for any costs and expenses, including legal fees, it may incur in connection therewith.

G. RUNAWAY EXPENSES. In the event the Resident runs away from the Program, Island View will make every reasonable effort to find the Resident and return the Resident to the Program or to the Sponsor. An accounting of the expenses incurred by Island View in finding and returning the Resident will be made to the Sponsor who agrees to accept full responsibility for any and all such costs and expenses, and to pay the same within seven (7) days of the Sponsor's receipt of said accounting.

H. LOSS OR DAMAGE TO RESIDENT'S PROPERTY. Island View is not liable for any loss of, or damage to any of the Resident's property. The Resident is fully responsible for the same at all times.

I. SUBCONTRACTING. Sponsor agrees and consents to Island View's subcontracting certain services to be rendered under this Agreement to persons or entities deemed by Island View to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. Island View is not responsible for the services provided by such third-party contractors and is hereby released from any liability arising from such services.

J. NURSING CARE. Island View provides only general nursing care unless, upon orders of the Resident's physician/nurse practitioner, the Resident is provided more intensive nursing care. If the Resident's condition is such as to need the service of a special duty nurse, it is agreed that the Sponsors must arrange such. Island View shall in no way be responsible for failure to provide the same and is hereby released.

K. ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY.
In consideration of services rendered or to be rendered, sponsor irrevocably assigns and transfer to Island View all rights, title and interest in the benefits payable for services rendered by Island View proved listed policy(ies) of insurance, but shall not be construed to be an obligation of Island View to pursue any such right or recovery provided, however, this assignment and transfer shall not take away Sponsor standing to make claim or sue for benefits individually, should coverage be denied by any insurance carrier(s). Sponsor authorizes the insurance company(ies) to pay directly to Island View all benefits due under said policy(ies) by reason of services rendered.

4. **ASSUMPTION OF RISKS; RELEASES AND INDEMNITIES.** Sponsor acknowledges that Island View offers a host of sports and recreational activities which can pose serious hazards and dangers, known and unknown, including but not limited to vocational activities, emotional and physical injuries, illness or death that may arise from strenuous hiking, climbing and camping in a natural environment, exposure to the elements, plants and animals, running away from the Program, "acts of God" (nature), the ropes course, kayaking, water sports, stress, involvement with other residents, self-inflicted injuries, and transportation to and from activities. Sponsor understands that in participating in the Program, Resident will be in locations and using facilities where many hazards exist and is aware of and appreciates the risks, which may result. Sponsor understands that accidents occur during such activities due to the negligence of others, which may result in death or serious injury. Sponsor and Resident are voluntarily participating in the Program with knowledge of the dangers involved and agree to accept any and all risks.

In consideration for being permitted to participate in the Program, Sponsor agrees to not sue, to assume all risks and to release, hold harmless and indemnify Island View and any and all of its predecessors, successors, officers, directors, trustees, insurers, employees, managers, agents, volunteers, community organizations, administrators, heirs, attorneys, executors, assigns and/or related or affiliated business entities including, but not limited to, Aspen Education Group, Inc. (collectively all of the above persons and entities shall be referred to as the "Released Parties" hereafter) who, through negligence, carelessness or any other cause, might otherwise be liable to Sponsor or Resident under theories of contract or tort law.

Sponsor intends by this Waiver and Release to release, in advance, and to waive his or her rights and discharge each and every one of the Released Parties, from any and all claims for damages for death, personal injury or property damage which Sponsor may have, or which may hereafter accrue as a result of Resident's participation in any aspect of the Program, even though that liability may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective property or equipment owned, maintained or controlled by them, or because of their possible liability without fault. Additionally, Sponsor covenants not to sue any of the Released Parties based upon their breach of any duty owed to Sponsor or Resident as a result of their participation in any aspect of the Program. Sponsor understands and agrees that this Waiver and Release is binding on his or her heirs, assigns and legal representatives and that the Released Parties shall be exempt from liability to Sponsor, his or her heirs, assigns and legal representatives.

Resident is physically capable of participating in the Program, and his or her medical care provider has approved his or her participation. If Sponsor is aware that Resident is under treatment for any physical infirmity, ailment or illness, Resident's medical care provider knows of and has approved Resident's participation in the Program. Sponsor acknowledges that Sponsor, and Sponsor alone, is solely responsible for Resident's personal health and safety, and the personal property Resident brings with him or her. Sponsor acknowledges that the medical insurance information Sponsor has provided on the Medical Form is current and complete and that Sponsor is solely responsible for procuring and maintaining all medical insurance Sponsor deems necessary and that the Released Parties have recommended that Sponsor procure and/or maintain medical insurance. Sponsor accepts full responsibility for any costs incurred for medical treatment due to failure to procure or maintain insurance, or providing outdated or falsified insurance information. Sponsor understands that it is ultimately Sponsor's responsibility to provide payment to any hospital/emergency response

technicians/emergency transport company that may provide services to Resident as a result of injury/illness during the Programs.

Sponsor agrees that this Release extends to all claims of every nature and kind whatsoever, and hereby expressly waives all rights under California Civil Code section 1542 which provides as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."

Sponsor agrees to indemnify the Released Parties from any and all actions, causes of action, claims, demands, damages, costs (including attorneys' fees), expenses, liabilities and charges, known or unknown (the "Liabilities") arising out of or in connection with claims and/or actions relating to or brought by or on behalf of Resident, including, without limitation, claims related to or arising out of the Minor's participation in the Program. **Initials:** _____.

5. **AUTHORIZATION FOR MEDICAL CARE AND RECORDS.** In the event of an accident, injury, illness, or other medical necessity, Sponsor hereby authorizes Island View to: (a) provide emergency first aid to the Resident at the facility, and in route to any hospital or clinic; (b) arrange for emergency medical, dental, psychiatric, hospital, ambulance or other health-related care for the Resident deemed necessary by Island View's staff; and (c) emergency authorization of a physician, dentist or other health-care professional(s) to perform any procedure(s) that the health-care professional(s) deems necessary for the well-being of the Resident. All costs and expenses incurred for these services shall be the sole responsibility of the Sponsor. Sponsor also authorizes Island View to arrange for a physical examination (including a drug screen urine/blood test, at Island View's option) and any psychological assessments of the Resident deemed necessary by Island View prior to the Resident's beginning the Program. Sponsor also authorizes any and all medical doctors, psychiatrists, psychologists, counselors, therapists, hospitals, clinics and treatment centers that have treated or counseled the Resident, and whose names Sponsor shall provide to Island View, to release all information regarding the Resident's medical and/or psychological history, diagnoses and treatments to Island View upon request. Island View shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") of 1996.

6. **AUTHORIZATION FOR SEARCH AND SEIZURE.** Sponsor hereby authorizes Island View personnel to search the person and personal effects of the Resident at any time. Island View is further authorized to confiscate any and all items deemed by Island View to be contraband or counterproductive to the Resident's successful completion of the Program. The disposition of all items confiscated by Island View shall be left to the sole discretion of Island View.

7. **AUTHORIZATION FOR BEHAVIOR MODIFICATION/THERAPEUTIC HOLDS.** Sponsor hereby authorizes Island View personnel to therapeutically hold, restrain, control and detain the Resident by the exercise of necessary techniques and holds when deemed necessary by Island View for purposes including but not limited to escorting the Resident to and from the Program's location, returning the Resident to the Program if the Resident runs away, or preventing the Resident from jeopardizing the Resident's own safety or the safety of others. In the event of a runaway, all appropriate law enforcement agencies or security personnel of any federal, state, county or municipal entity are hereby directed to detain and retain custody of the Resident until Sponsor or any personnel of Island View arrive, at which time Island View personnel may re-obtain custody or control of the Resident or authorize continued custody by the law enforcement agency until travel is arranged for the Resident's return home.

8. **BENEFITS AND RISK ASSOCIATED WITH TREATMENT.** Sponsor hereby acknowledges to have received a Parent/Resident Handbook, which delineates the benefits and risk associated with the treatment provided at Island View. Throughout the stay, the sponsor may ask for further clarification with regard to the benefits and risk associated with treatment.

9. **STILL PHOTOGRAPH AUTHORIZATION.** Sponsor gives permission to Island View staff to take still photographs of the Resident for identification purposes. Sponsor further acknowledges that those photographs will remain in the Resident's medical record. Sponsor gives permission to have still photographs of the Resident displayed for decorative purposes in the residential area only and not in public waiting areas. Sponsor

further gives permission to use audiovisual equipment to record individual, group and family therapy sessions for internal staff training purposes only.

10. **RESEARCH AUTHORIZATION**. Sponsor hereby authorizes Island View to use data from the Resident's records, tests, and assessments for purposes of ongoing research, provided that the Resident's name and identity will be kept confidential and not used in any published materials.

11. **EARLY TERMINATION BY ISLAND VIEW/LIQUIDATED DAMAGES.** Island View reserves the right to terminate this Agreement at any time due to: (i) failure of Sponsor to pay any amounts due under paragraph 4 and (ii) illegal behavior by the Resident. **In the event that Island View elects to terminate the Resident pursuant to the terms of this paragraph, Sponsor understands and agrees that Sponsor shall immediately (1) pay all outstanding account balances and tuition through the end of the month in which the Resident is terminated and (2) forfeit the prepaid tuition deposit.** The forfeiture of the last month's pre-paid tuition reflects the recognition that certain costs associated with making the program available to the Resident are incurred, whether or not the program is completed, including such items as salaries, inventories, and other general operating expenses. Therefore, Sponsor understands and agrees that the policy of non-refundable payments and expenses is a reasonable estimate of the losses (i.e., Liquidated Damages) the program incurs with the early termination of Resident. **If applicable, Sponsor shall be refunded any remaining tuition thereafter.**

    If, during the course of treatment, Island View, in its sole discretion, determines that the resident's clinical needs can no longer be met through the program delivery system, resulting in the termination from the program, sponsor shall immediately pay all outstanding account balances. Island View will refund the residual tuition depots.

12. **SPONSOR EDUCATION PROGRAM AND COOPERATION.** Sponsor agrees to exercise good faith best efforts to attend any seminars for parents and guardians of the residents conducted by Island View during the Program, and to give Sponsor's full cooperation to Island View personnel throughout the Program, in order to maximize the benefits of the Program for the Resident and the Sponsor. Sponsor also agrees to read any educational materials and watch any video programs sent to Sponsor by Island View, and to fill out and return to Island View any interactive educational materials, while the Resident is in the Program.

13. **ESCORTS.** If an escort is required to bring the Resident to Syracuse, Utah for the Program, or to return the resident from Utah or for any other transport deemed necessary by Island View, Sponsor agrees that any escort or escort service used by Sponsor, whether or not Sponsor is referred to the escort by Island View, is in all respects an independent contractor contracting directly with Sponsor. Sponsor agrees that Island View bears no responsibility of any kind for any such escort service or the negligence or failure thereof.

14. **HEALTH INSURANCE.** Sponsor warrants that the Resident is presently covered, and will for the duration of the Program be covered, by adequate health insurance covering claims that may arise in connection with any accident, injury or illness that the Resident may suffer or incur during the Program; or take personal financial responsibility for such costs. Whatever deductibles or coverage exclusions may apply in a given case shall be satisfied entirely by Sponsor.

15. **EMANCIPATION.** Sponsor warrants that the Resident is a minor, both by age and as a matter of law, which the Resident does not qualify under the law as an "emancipated minor," and that the laws of the Resident's state of residence permit Sponsor to place the Resident in the Program without the Resident's consent.

16. **DELAYED PERFORMANCE.** Except for the obligation to make payments when due hereunder, all other obligations under this Agreement shall be suspended for so long as one or both Parties hereto are prevented from performing hereunder by acts of God/nature, the elements, acts of federal, state or local governments, agencies or courts, damage to or destruction or unavoidable shutdown of necessary facilities, or other matters beyond their reasonable control; provided, however, that any party so prevented from complying with its obligations hereunder shall promptly notify the other party thereof and shall exercise due diligence to remove and overcome the cause of such inability to perform as soon as practicable.

17. **BINDING ARBITRATION.** Any controversy or claim arising out of or relating to this contract, except at Island View's option the collection of monies owed by Sponsor to Island View, shall be settled by binding arbitration conducted in the State of California in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction for purposes of executing upon the award.

18. **ATTORNEY'S FEES.** In the event that either party is found in default or material breach of any specific promise, term or condition expressly set forth in this Agreement by an arbitrator(s) or a court of competent jurisdiction, said party shall be liable to pay all reasonable attorneys' fee, court costs and other related collection costs and expenses incurred by the other party in enforcing its contractual rights hereunder in said arbitration and/or court proceeding(s). In addition, Sponsor agrees to compensate Island View for all reasonable attorneys' fees and costs incurred by Island View in connection with those matters concerning which Sponsor has agreed to pay or indemnify Island View hereunder.

19. **NOTICES.** Any and all notices, payments, reports and other correspondence required hereunder shall be deemed to have been properly given or delivered when made in writing and delivered personally to the party to whom directed, or when sent by United States mail with all necessary postage or charges fully prepaid, and addressed to the party to whom directed at its below specified address (or a new address after written notice of such change is given to the other party).

ISLAND VIEW
c/o CRC Health Group
20400 Stevens Creek Blvd.
6th Floor
Cupertino, CA 95014

PARENT'S NAME:_____
ADDRESS: _____
_____

20. **AMENDMENTS.** This agreement may be amended at any time upon mutual agreement of the parties hereto, but any amendment(s) must first be reduced to writing and signed by both parties in order to become effective.

21. **WAIVER.** A waiver by any party of any provision hereof, whether in writing or by course of conduct or otherwise, shall be valid only in the instance for which it is given, and shall not be deemed a continuing waiver of said provision, nor shall it be construed as a waiver of any other provision hereof.

22. **PARAGRAPH HEADING.** The paragraph headings of this Agreement are inserted only for convenience and in no way define, limit or describe the scope or intent of this Agreement or affect its terms and provisions.

23. **GOVERNING LAW/VENUE.** This Agreement, and all matters relating hereto, including any matter or dispute arising between the parties out of this Agreement, tort or otherwise, shall be interpreted, governed, and enforced according to the laws of the State of California; and the Parties consent and submit to the exclusive jurisdiction and venue of the California Courts in Los Angeles County, California, and any qualified (American Arbitration Association-approved) arbitration service in the State of California, County of Los Angeles, to enforce this Agreement. The parties acknowledge that this agreement constitutes a business transaction within the State of California.

24. **SEVERABILITY.** In the event that any provision of this Agreement, or any operation contemplated hereunder, is found by a court of competent jurisdiction to be inconsistent with or contrary to any law, ordinance, or regulation, the latter shall be deemed to control and the Agreement shall be regarded as modified accordingly and, in any event, the remainder of this Agreement shall continue in full force and effect.

25. **NUMBER.** As used in this Agreement, the term "Sponsor" shall include all Sponsors, being the parent(s) and/or guardian(s) executing this Agreement; and singular pronouns shall include the plural and plural pronouns shall include the singular, whenever the context so requires.

26. **ACKNOWLEDGMENT/ENTIRE AGREEMENT.** Sponsor hereby acknowledges that Sponsor has read this agreement and that Sponsor understands and consents to all of its provisions; that this Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter hereof; and that all other prior agreements, promises, expectations and conditions, oral or written, between the parties are incorporated herein. Other than the express commitments set forth in this Agreement and the Program description, Island View gives no warranties of any kind, express or implied, to either the Sponsor or the Resident concerning the Program; and Sponsor acknowledges that Sponsor is not relying on any warranties or representations of any kind other than the express commitments of Island View set forth herein.

27. **BINDING EFFECT.** This Agreement shall be binding upon and inure to the benefit of the parties hereto, their heirs, personal representatives, successors and assigns.

28. **RELEASE OF INFORMATION.** The parties authorize the release of the Resident's information via E-mail, Internet technology, voicemail or US mail. While every effort will be made to maintain confidentiality, Island View accepts no responsibility for the mis-transmission that could result in information becoming available to someone other than the intended receiver. Island View shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") of 1996.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the dates set forth below.

_____ _____
Sponsor (Father/Guardian) Date

_____ _____
Sponsor (Mother/Guardian) Date

Accepted:

_____ _____
Island View Residential Treatment School Date
(ISLAND VIEW)

Island View

Residential Treatment Center

Consent for Disclosure of Confidential Information

FOR THE RECIPIENT OF THE INFORMATION:

The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted under Federal rules. With respect to information regarding alcohol or drug abuse treatment, a general authorization for the use or release of medical or other information is NOT sufficient. In such a case, Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1. Pursuant to Federal Guidelines concerning my right to confidentiality, I, _____ DOB: _____
   (Patient/Resident/Student Name)
   authorize _____
   (Person/Organization making disclosure)
   to release/disclose confidential information to: _____
   (Person/Organization receiving disclosure)

2. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. The information to be used or released includes:

   - ❑ Psychological Evaluation
   - ❑ Psychiatric Evaluation
   - ❑ Psycho-Social History
   - ❑ Discharge Summary
   - ❑ Laboratory Data
   - ❑ Treatment Plans
   - ❑ Consultation Reports
   - ❑ Assessments
   - ❑ Progress Notes
   - ❑ Medical Records
   - ❑ X-ray Reports
   - ❑ Medication Records
   - ❑ Monthly Progress Report
   - ❑ Parent Check In
   - ❑ Other: _____
   - ❑ Verbal Communication with: _____

3. The above information is to be released for the following purpose:

   - ❑ For evaluative purposes to determined if the patient/resident/student meets admission criteria for Island View RTC.
   - ❑ For continuation of care at Island View RTC.
   - ❑ For continuation of care at: _____
   - ❑ Other: _____

4. I authorize the release of such information by mail, fax, regular telephone, and/or cellular phone contact.

5. I understand that unless I revoke the authorization earlier, this authorization will automatically expire 60 days after the resident's discharge from Island View RTC or on: (date, event, condition): _____

6. I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.

7. This authorization is limited to only that information that I have requested above to be used or disclosed to the person/facilities named herein. I hereby release Island View RTC from all legal responsibilities or liability that may arise from the use of disclosure of medical records and other health information in reliance on this authorization.

8. Pursuant to Utah State rules, I understand that in case I am below the age of 18, my parent/legal guardian reserves the right to sign this release without my expressed verbal or written consent.

Certification: I certify that I am (check whichever applies):

- ❑ The patient/resident/student, and the identification that I have provided is true and correct.
- ❑ The patient/resident/student authorized representative, and the identification and proof of authority that I have provided are true and correct. My relationship to the resident is that of: _____

Resident Signature: _____ Date: _____

Parent/Legal Guardian Name:_____ Date: _____
Print Signature

Witness Signature: _____ Witness Signature (by phone): _____ Date: _____

ISLAND VIEW

Credit Card Authorization

I hereby give my consent to Island View RTC, LLC, to charge my credit card each month for services rendered. I understand that if my credit card declines, late fees of $50.00 may be assessed. It is my responsibility to phone the Island View Business Office if a card change is needed. I also understand the tuition due date and the tuition charge is outlined in the financial agreement. Please charge my tuition fee each month to the following credit card:

- American Express Card Number:_____Expiration:_____
- Visa Card Number:_____Expiration:_____
- Mastercard Card Number:_____Expiration: _____

Exact Billing Name and Address as shown on the above credit card statement:

_____
_____
_____
_____

I also give my consent for Island View to charge my credit card for charges related to shipping costs of my son/daughter's personal belongings as they are incurred. The charge will also include a $2.00 processing fee per shipment. If I have a different credit card in which to charge this amount, I will note it below, along with the full name of the cardholder, as well as exact billing address:

Card Type & Number:_____Expiration:_____

_____
_____
_____
_____

By signing below, I understand and agree to the above statements relating to charges to my credit card and authorize Island View RTC, LLC to process such transactions related to my child's confinement.

Signature of Card Holder:_____Date:_____

Island View
Residential Treatment Center

Communication Form

Mail Policy

When Residents desire to mail any material to any person, they are required to provide the material to the Center, sealed, in an envelope or other package, without postage. The Center then takes the package or envelope, without opening or inspecting the contents, and forwards the envelope or package to the resident's parent or legal guardian. Likewise, when any mail from any person other than from those whose names are listed below arrives at the Center addressed to a resident, the Center takes that mail, unopened, and forwards the mail to the assigned primary therapist. The therapist will then contact the resident's parent or legal guardian for approval of that mail. Please note that parent or legal guardian may contact the primary therapist with updates to the mailing list throughout resident's entire stay.

I, _____ Parent/ Legal Guardian of _____
Name of Parent Resident Name
Wish that the mail to and from my child is processed in the above specified manner.

Approved Mail List

Name/ Relation:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
Parent/ Legal Guardian Signature Date

Island View

Residential Treatment Center

Consultation Release Form

Purpose: During the course of your child's stay at Island View, it may become necessary for him/her to seek treatment from an outside Consultant and/or services such as a Dentist, OB/GYN, Orthopedic, Optometry, E.N.T., etc. You are responsible for the cost associated with these services. I understand that Island View will seek parent/guardian approval prior to scheduling such consultations.

ACKNOWLEDGMENT

I, _____, am aware that I am
Name of Parent/Guardian
responsible for all costs related to outside consolation services in behalf of _____ during his/her
Name of Resident
stay at Island View. I am aware that the provider of the consultation service will bill me and/or my insurance company for the services provided.

INSURANCE INFORMATION

Insurance #1:_____ Phone #:_____

Policy Number: _____Group #:_____

Insurance #2: _____ Phone #:_____

Policy Number: _____ Group #:_____

_____

Signature (Parent/Guardian) Date

Island View Residential Treatment Center.

Laboratory Services Enrollment

Resident Name: _____ Date of Birth_____

Parent/Guardian: _____

Billing Address: _____

State: _____ Zip Code: _____

Telephone Number where you can be contacted: _____

Known Allergies of Resident: _____

Insurance Information:

Name of Primary Insurance: _____

Who is the insured? _____

Insured Social Security number: _____

Group Number: _____
(Please attach copies of all insurance cards)

I hereby authorize PAML Biolabs to bill my insurance company for laboratory services rendered and authorize my credit card to be billed for any balance due.

Signature: _____ Date: _____

Island View Pharmacy
2038 W. 1900 S.
Syracuse, UT. 84075
(801) 773-7899 Fax (801) 773-7338

Agreement for Services

Island View Pharmacy (no affiliation with IVRTC) provides services to Island View Residential Treatment Center (IVRTC) including but not limited to: medical supplies, medications, and packaging. Patients who receive services from Island View Pharmacy must complete the following agreement. Island View Pharmacy will bill the appropriate insurance when applicable, but the patient/responsible party will be responsible for any non-covered charges. If no insurance is indicated, or a copy of the insurance card (front and back) is not included, Island View Pharmacy will bill the patient/responsible directly for any and all charges.

Resident information (please print)
Name_____ Male ☐ Female ☐ Date of Birth_____
SS#_____ Allergies_____ Diagnosis_____

Billing Status (check one box)
☐ Please bill my insurance - Island View Pharmacy will bill insurance directly whenever possible. The patient/responsible will be billed for deductible, co-pay, coinsurance, non-covered charges, and denied claims. **PLEASE ATTACH A COPY OF THE PRESCRIPTION INSURANCE CARD (FRONT AND BACK)**
☐ Please bill me directly - Island View Pharmacy will bill patient/responsible party directly, **NO INSURANCE WILL BE BILLED**.

Bill direct or by credit card (check one box)
☐ Please bill my account directly - Island View Pharmacy will mail you a statement monthly.
Send statements to (billing address) Mr./Mrs./Ms._____
Relationship to Resident_____
Street_____ City_____
State_____ Zip_____ Phone_____

☐ Please bill my credit card - Island View Pharmacy will charge you credit card (a statement will not be mailed)
The following information is REQUIRED in order to bill your credit card directly
Name on Credit card_____ Relationship to Resident_____
Address where statement is mailed to _____
City_____ State_____ Zip_____ Phone_____

Credit card #_____ Expiration Date_____
Valid Drivers License#_____Expiration Date_____

Pharmacy Insurance Information
Insurance Company_____ Phone_____
Policy Holder_____ SS#_____
Policy Number_____ Group_____

Emergency Contact
Name_____ Relationship to Resident_____
Street_____City_____
State_____ Zip_____ Phone_____

Please read and sign
I understand that by signing this agreement I indicate my wish to purchase health care products/services from Island View Pharmacy. I will pay for any co-pays, non-covered items, and any charges that incur while under this agreement. I authorize Island View Pharmacy access to the above mentions patient's medical records for proper medication assessment. By signing I also indicate that I have received a Notice of Privacy Practices. I understand that this notice explains the uses and disclosures of protected health information (PHI) that may be made by Island View Pharmacy as well as my rights as a patient and Island View Pharmacy's duties with respect to PHI. I understand that if my account is 60 days or more past due Island View Pharmacy will stop services until payment is made. If my account is sent to collections, I agree to pay a collection fee of 33.3%.

_____ _____
Signature of responsible party Date

Island View Pharmacy Agreement Addendum

Island View RTC uses a bubble packed medication administration system through Island View Pharmacy (no affiliation with Island View RTC). Island View Pharmacy will bubble pack medications mailed from home for a $5 fee per card for the time and liability of packaging items that did not originate from within their pharmacy. The medications or vitamins are packed in one card for each time of day each month. Medication given on an as needed basis will be packaged 30 pills per card. (For example, a medication given 3 times daily will be packed in 3 separate cards and is subject to a $15 per month packaging fee). Island View RTC does not receive any monetary compensation whether or not you use Island View Pharmacy.

Island View pharmacy will bubble pack medications brought in at admission for no additional fee if the prescription is transferred to Island View pharmacy and the quantity is for 30 days or less.

Considering the cost for you to ship medication and the packaging fee, it may be less expensive to purchase medications or vitamins directly from Island View Pharmacy. You may call the pharmacy directly for their medication/vitamin pricing. The phone number is (801) 773-7899. Lori is the contact person, but any of their staff should be able to answer pricing questions.

Please indicate your wishes below by marking the applicable box

- ☐ Please have all medications and vitamins filled at Island View Pharmacy according to Island View Pharmacy agreement
- ☐ Please fill all medications at Island View Pharmacy according to previous contract except for the following which I will mail to Island View RTC:

  _____

  _____

  _____

  _____
- ☐ Please use Medication/Vitamins currently at Island View, then fill at Island View Pharmacy according to previously signed contract.
- ☐ Please do not fill medications at Island View Pharmacy, I will mail them to Island View RTC.

I understand that medications bubble packed by Island View pharmacy are subject to an additional $5 per card fee. This form does not replace, but is an addendum to the Pharmacy Agreement for Services contract with Island View Pharmacy.

_____ _____

Signature of Parent/Guardian Date

Island View Pharmacy
2038 West 1900 South
Syracuse, Utah 84075
773-7699

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Pharmacy is required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

The Pharmacy is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Your Health Information Rights

You have the following rights with respect to PHI about you:

Obtain a paper copy of the Notice upon request. You may request a copy of the Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. To obtain a paper copy, contact Island View Pharmacy.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of PHI about you by sending a written request to Island View Pharmacy. We are not required to agree to those restrictions.

Inspect and obtain a copy of PHI. You have the right to access and copy PHI about you contained in a designated record set for as long as the Pharmacy maintains the PHI. The designated record set usually will include prescription and billing records. To inspect or copy PHI about you, you must send a written request to Island View Pharmacy. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to PHI about you, you may request that the denial be reviewed.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must send a written request to Island View Pharmacy. You must include a reason

that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of PHI about you after April 14, 2003 for most purposes other than treatment, payment, or health care operations. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, and disclosures for notification purposes. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to Island View Pharmacy.
Your request must specify the time period, but may not be longer than six years. The first accounting you request within a 12 month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

Request communications of PHI by alternative means or at alternative locations. For instance, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of PHI about you, you must submit a request in writing to Island View Pharmacy.
Your request must state how or where you would like to be contacted. We will accommodate all reasonable requests.

Examples of How We May Use and Disclose PHI

The following are descriptions and examples of ways we use and disclose PHI:

We will use PHI for treatment. Example: Information obtained by the pharmacist will be used to dispense prescription medications to you. We will document in your record information related to the medications dispensed to you and services provided to you.

We will use PHI for payment. Example: We will contact your insurer or pharmacy benefit manager to determine whether it will pay for your prescription and the amount of your copayment. We will bill you or a third-party payor for the cost of prescription medications dispensed to you. The information on or accompanying the bill may include information that identifies you, as well as the prescriptions you are taking.

We will use PHI for health care operations. Example: The Pharmacy may use information in your health record to monitor the performance of the pharmacists providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

We are likely to use or disclose PHI for the following purposes:

Business associates: There are some services provided by us through contracts with business associates. Examples include Our Attorney and Collection Company.

When these services are contracted for, we may disclose PHI about you to our business associate so that they can perform the job we have asked them to do and bill you or your

third-party payer for services rendered. To protect PHI about you, we require the business associate to appropriately safeguard the PHI.

Communication with individuals involved in your care or payment for your care: Health professionals such as pharmacists, using their professional judgment, may disclose to a family member, other relative, close personal friend or any person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

Health-related communications: We may contact you to provide refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose PHI about you as authorized by and as necessary to comply with laws relating to worker's compensation or similar programs established by law.

Public health: As required by law, we may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena or other legal process.

As required by law: We must disclose PHI about you when required to do so by law.

Health oversight activities: We may disclose PHI about you to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and administrative proceedings: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

We are permitted to use or disclose PHI about you for the following purposes:

Research: We may disclose PHI about you to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, medical examiners, and funeral directors: We may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to carry out their duties.

Organ or tissue procurement organizations: Consistent with applicable law, we may disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising: We may contact you as part of a fundraising effort.

Notification: We may use or disclose PHI about you to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and your general condition.

Correctional institution: If you are or become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

To avert a serious threat to health or safety: We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and veterans: If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.

National security and intelligence activities: We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective services for the President and others: We may disclose PHI about you to authorized federal official so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Victims of abuse, neglect, or domestic violence: We may disclose PHI about you to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Other Uses and Disclosures of PHI

The Pharmacy will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except to the extent that we have already taken action in reliance on the authorization.

For More Information or to Report a Problem

If you have questions or would like additional information about the Pharmacy's privacy practices, you may contact the **[Privacy Officer]** at **[Island View Pharmacy]**. If you

believe your privacy rights have been violated, you can file a complaint with the **[Privacy Officer]** or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective Date
This Notice is effective as of **[4-14-03]**.

Privacy Officer : Shawn Spriggs R. Ph.

Island View
Residential Treatment Center

Dear Parent/Guardian,

In an effort to coordinate your child's medication administration, it is necessary for you to complete the Prescription Drug Enrollment form. This form allows us to fill the medications that the Physician has prescribed in a timely manner without delaying the administration to your child.

Please indicate what medication your child is currently taking. Efforts will be made to continue these medications until reviewed with the attending Physician. After admission, permission will be obtained from you prior to starting any new medication. (Except in an emergency situation)

If you have further questions or concerns, please contact the nursing staff at (801) 773-0200, extension 117.

Thank you for your assistance in this matter as it will expedite the process in obtaining and administrating medication for your child.

Medication and Dosage Your Child is Currently Taking:

_____
_____
_____
_____
_____
_____

I hereby authorize Island View Residential Treatment Center to continue the medication my child is currently taking.

_____ _____
Signature/Relationship to Child Date

Island View
Residential Treatment Center

CONSENT FOR OVER THE COUNTER MEDICATION (OCM) ADMINISTRATION

Resident Name: _____ Admit Date: _____

During the stay of a resident at Island View, it may become necessary to administer over the counter medication (OCM) for symptom relief. The medical and/or nursing staff will decide which medications are indicated for the illness. Nursing staff and Milieu Management staff dispenses the following medications with administration guidelines outlined by the physician.

If there are any medications **YOU DO NOT WANT YOUR CHILD TO RECEIVE,** please indicate by marking that particular medication.

- ☐ Ibuprofen (Advil, Motrin)
- ☐ Tylenol
- ☐ Sudafed
- ☐ Benadryl
- ☐ Cough drops/Throat Lozenge
- ☐ Imodium
- ☐ Tums
- ☐ Guiatuss DM expectorant
- ☐ Hydrocortisone Cream
- ☐ Tinactin Cream
- ☐ Bacitracin Zinc ointment
- ☐ Claritin
- ☐ Pepcid AC
- ☐ Fiber Tablets
- ☐ Milk of Magnesia
- ☐ Artificial Tears
- ☐ Saline solution flush
- ☐ Magic Mouth Wash #2 (Benadryl, Maalox, Hydrogen peroxide)

If the resident has allergies to agents he/she may come in contact with suddenly and/or unpredictable such as bee stings, or hidden food items that have cause severe reactions, it is imperative that you indicate this on the Health History section of our Health History Form and on this form. Medication such as an Epi-pen should be made available at all times when potential contact with an allergen is possible.

Allergies (mediation, food, other):

_____

_____

_____

Parent/Legal guardian Signature Date

Island View

Residential Treatment Center

Resident Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about the minor child. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy from our website, www.islandview-rtc.com, or by calling Island View RTC at 801-773-0200.

You have the right to request that we restrict how protected health information about the minor child is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about the minor child for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____

Print Name of Minor Child

_____

Print Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian of Minor Child Date

_____ _____

Witness and position Date

Island View

Residential Treatment Center

Confidentiality of School and Other Records

Confidentiality

All residents and their parents/guardians have the right to privacy. In other words, Island View, pursuant to federal law, will not disseminate any information about its residents and/or parents/guardians without the expressed written consent from said parent/guardian.

We urge all residents and their parents/guardians to respect the privacy to confidentiality right by not disseminating any information about other Island View residents, parents and/or guardians.

Confidentiality of School and Other Records

Pursuant to federal law, all institutional records, including educational records are subject to confidentiality. Hence, any and all records pertaining to a resident are only released upon written consent from legal guardian.

Legal guardians have access of official records (including educational records) of their children under the age of 18.

These rights transfer to residents at the age of 18 years of age. School records are released to any resident, even if under the age of 18, if said student is attending a post-secondary educational institution.

_____

Signature of Resident Date

_____

Signature of Parent/Guardian Relationship Date

_____

Witness Position Date

Island View
Residential Treatment Center

Resident, Families or Guardian Complaint Policy

(Revised 06/16/10)

Purpose:

Pursuant to the Island View Resident Rights, Section 12.14, the resident, any of his/her family members, or the legal guardian of the resident has the right to initiate a complaint or grievance regarding the resident care delivery system. Those complaints may include, but are not limited to allegations of abuse, neglect, punitive interventions, sexual harassment, etc.

Procedure:

If such party wishes to file such a complaint, the following procedure shall be followed:

1. Residents, Families, or Guardians shall contact either the Primary Therapist, Clinical Director, or the Executive Director and lodge an oral complaint.

2. The respective staff member fielding the complaint will immediately report the complaint to their respective supervisor who will investigate the complaint by conducting interviews, seeking collaborating evidence, obtaining feedback and gathering other additional information to ascertain a thorough understanding of the facts surrounding the complaint.

3. Following the investigation, the respective staff member will present to the complaining party his/her findings and proposed solution(s) to the presented problem and document the results of this meeting.

4. If the complaining party is not satisfied with the proposed solution, the complaining party may file a written complaint utilizing the *"Resident/Family/Guardian Complaint Form."*

5. The *"Resident/Family/Guardian Complaint Form"* will be immediately forwarded to the Executive Director or his designee who will, within ten (10) days, conduct his/her own formal investigation of the complaint and document the findings of the investigation, determinations, and plan of correction or action plan for proper resolution of the problem in the corresponding sections of the *"Resident/Family/Guardian Complaint Form."*

6. Following the investigation the Executive Director or his designee will present the findings of the investigation, determinations, and plan of correction or action plan for proper resolution of the problem to the complaining party.

7. If the complaining party is not satisfied with the outcome and/or proposed solution(s) from the investigation, the complaining party may appeal to the Division Head of the parent company of Island View, RTC, who will, in turn conduct further investigation and provides a proposed solution to the complaint.

8. If the complaining party is still not satisfied with the proposed solution, the complaint will be forwarded to the State of Utah, Department of Human Resources, and Office of Licensing who will further investigate the complaint. It is the policy of Island View, RTC to work closely with the Office of Licensing to resolve all complaints and to put in place any recommendations once they have been determined.

9. As a Joint Commission accredited behavioral health care facility, Island View, RTC adheres to the requirements as defined in the "Standards for Behavioral Health Care" developed by the Joint Commission for accreditation. The complaining party may also contact the Joint Commission with concerns or questions about the safety and quality of care of individuals served.

Island View Residential Treatment Center

This is to acknowledge that I have received a copy of the Resident, Family, or Guardian Complaint Policy. I acknowledge that if I have a complaint I know the process to follow and what I need to do if I am not satisfied with the outcome.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness and Position Date

Immunization Records

An important document to be included with the Admission Paperwork is documentation of proper immunizations given to your child. In Utah, no student is permitted to attend school without proof of proper immunizations.

If you currently have such documentation, please send it with the Admission Paperwork. If you do not have a current immunization record, we have provided a copy of the Utah School Immunization Record card that we would ask that you have your child's physician fill out for our use. We do not need both, just one or the other.

If you have any questions, please contact the admission staff or education staff. We appreciate your timely assistance with this matter.

Utah Department of Health
IMMUNIZATION PROGRAM
Immunize for healthy lives

UTAH SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent school record (cumulative folder) as defined in Section 53A-11-304 of the Utah Statutory Code and shall transfer with the student's school record to any new school. The Utah Department of Health and local health departments shall have access to this record. This immunization record may be entered into the Utah Statewide Immunization Information System (USIIS). For more information about USIIS, please visit the USIIS website at www.usiis.org or see the Family Educational Rights and Privacy Act (FERPA) directory.

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

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

Name of Parent/Guardian _____ **Signature of Parent/Guardian** _____

Mailing Address _____ **City** _____ **Zip Code** _____ **Telephone** _____

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

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

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

SCHOOL AND EARLY CHILDHOOD PROGRAM USE ONLY:

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

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

Signature of Parent/Guardian:

_____

Today's Date _____

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

Authorized Signature _____ **Date** _____

☐ Physician ☐ School or Early Childhood Program Official ☐ Health Authority

Utah Department of Health
Division of Community and Family Health Services
Immunization Program 03/02

INSTRUCTIONS

1. **The minimum required immunizations for school or early childhood program entry include:**
   - **5 doses of DTaP/DTP/DT** – 4 doses are acceptable if the 4th dose was given after the 4th birthday; 3 Td required if started after age 7.
   - **4 doses of Polio** – 3 doses are acceptable if the 3rd dose was given after the 4th birthday;
   - **2 doses of Measles** – required for all students kindergarten through grade 12. Two doses of Measles, Mumps, and Rubella (MMR) vaccine are acceptable. The first dose of measles containing vaccine must be given on or after the 1st birthday.
   - **1 dose of Mumps** – must be given on or after the 1st birthday.
   - **1 dose of Rubella** – must be given on or after the 1st birthday.
   - **4 doses of Haemophilus Influenzae type b (Hib)** – dosing schedule is based upon student's current age and number of previous doses received. *Hib is not required for kindergarten entry.*
   - **3 doses of Hepatitis B** – required for students born after July 1, 1993 prior to entering kindergarten. *It is not required to attend an early childhood program.*
   - **1 dose of Varicella (chickenpox)** – EFFECTIVE JULY 1, 2002 – required for students born after July 1, 1996 prior to entering kindergarten. It must be given on or after the 1st birthday. Parental history of the disease is acceptable. Parent/Guardian must sign verifying history of disease.
   - **2 doses of Hepatitis A** – EFFECTIVE JULY 1, 2002 – required for students born after July 1, 1996 prior to entering kindergarten. The first dose of Hepatitis A must be given on or after the 2nd birthday.

2. **Fill in (print or type) student's name, gender, and date of birth.**

3. **Fill in (print or type) name of parent/guardian, mailing address, city, zip code, and telephone number. Parent/Guardian must sign.** Also complete information regarding health insurance.

4. **Written proof is required to verify the student's immunizations.** Proof may be obtained from physician records, health department records, or parent/guardian records. Parent/guardian records may be accepted if they indicate the student's name, date of birth, type of vaccine administered, specific dates of immunization, and the name of physician or health care facility administering the vaccine.

5. **Transcribe the month, day, and year of each immunization received by the student in the appropriate box.**

6. **Complete the "SCHOOL AND EARLY CHILDHOOD PROGRAM USE ONLY" box.**
   a. Determine if admission requirements for all required immunizations have been met. If all requirements have been met, enter "Date of Unconditional Admission – ALL REQUIREMENTS MET". If all requirements have not been met, but the student has received at least one dose of each required vaccine, enter "Date of Conditional Admission" and explain the process of completing required immunizations to parent/guardian.
   b. If a student is exempted for medical reasons and the duration of the medical condition is temporary, enter "Date of Conditional Admission". Upon expiration of temporary status, immunizations shall be required. If the medical exemption is permanent, the student shall be considered as having met all requirements. Complete date for ALL REQUIREMENTS MET and check the box marked medical exemption granted.
   c. If a student is exempted for religious or personal beliefs, the student shall be considered as having met all requirements. Complete date for ALL REQUIREMENTS MET and check the box marked religious or personal exemption granted.
   d. Fill in date(s) immunization records were verified.

7. **Complete authorized signature and date.**

8. **Exemption Procedures:**
   a. MEDICAL EXEMPTION: If a medical exemption is claimed, a Medical Exemption Form must be completed and signed by the student's licensed physician (Utah Statutory Code – Section 53A-11-302). The Medical Exemption Form may be obtained from the student's physician. It must indicate whether the exemption is to one or all immunizations. The WHITE and YELLOW copies will be given to the parent/guardian. The parent/guardian will present the WHITE copy to the school or early childhood program official. The WHITE copy must be attached to this record. The YELLOW copy is for the parent/guardian. The PINK copy will remain in the child's medical record.
   b. RELIGIOUS EXEMPTION: If a religious exemption is claimed, a Religious Exemption Form must be completed and signed by the parent/guardian. The Religious Exemption Form may be obtained from a local health department. A local health department representative must witness and sign the Religious Exemption Form giving the WHITE and YELLOW copies to the parent/guardian. The parent/guardian will present the WHITE copy to the school or early childhood program official. The WHITE copy must be attached to this record. The YELLOW copy is for the parent/guardian. The PINK copy will remain with the local health department.
   c. PERSONAL EXEMPTION: If a personal exemption is claimed, a Personal Exemption Form must be completed and signed by the parent/guardian. The Personal Exemption Form may be obtained from a local health department. A local health department representative must witness and sign the Personal Exemption Form giving the WHITE and YELLOW copies to the parent/guardian. The parent/guardian will present the WHITE copy to the school or early childhood program official. The WHITE copy must be attached to this record. The YELLOW copy is for the parent/guardian. The PINK copy will remain with the local health department.

Island View School: Academic Information

In order to determine the most appropriate academic schedule for your child, it is imperative that all academic transcripts and records of previous grades and credit earned are forwarded to Island View. Not having these records on hand may jeopardize your child's placement in the classes he or she is required to complete for high school graduation. Please make arrangements for these records to be forwarded as soon as possible to Island View to the attention of:

Alayna Bean, Registrar
2650 W 2700 S
Syracuse, UT 84075

In addition to having the official academic records on hand, we appreciate your help in determining the most appropriate schedule and academic support for your student by providing us with the following information on the form below.

Name of Student: _____

Current Grade Level: _____

Approximate Date Student was Last in School: _____

Please provide us with information regarding the previous schools attended.

NAME OF SCHOOL	GRADE/DATES ATTENDED	CONTACT INFORMATION – INCLUDE LOCATION/ADDRESS, PHONE/FAX NUMBER, CONTACT NAME, ETC. IF AVAILABLE

Please list the classes your child was most recently enrolled and the letter grade they were earning if available. Please be specific with class names. For instance, state Biology, instead of Science.

1) _____ Grade: ____ 4) _____ Grade: ____
2) _____ Grade: ____ 5) _____ Grade: ____
3) _____ Grade: ____ 6) _____ Grade: ____

Does your child have a current/active IEP or 504 plan? _____

If yes, please list any accommodations that were provided through the IEP/504 Plan.

1) _____

2) _____

3) _____

Please provide Island View with a complete copy of the most current IEP/504 plan as soon as possible. Please forward these documents to the attention of: Laura Burt, Registrar, at the address listed above.

Person completing this form: _____ Date: _____

Island View Residential Treatment Center

Computer and Internet Use Policy

All students and parents must sign the following "Computer and Internet Use Policy" upon admission to Island View. This form ensures that all residents and their parents understand the parameters under which students are allowed to have and use computers at Island View.

Island View is equipped with a computer lab for students to use for assigned school work and research. Students must abide by the following rules when using computers at Island View:

1. Students are assigned a user name and password upon enrollment of classes at Island View. Students may log onto the computer only under their user name and password.
2. Students may not share their user name and password with other residents, even members of the same team.
3. Students may not access or try to access documents stored under any user name and password other than the one they have been assigned.
4. Students must have a signed permission slip to use the internet. This permission slip is signed by the classroom teacher who has assigned research for school work. Students must state on their permission slip a specific subject they will be researching and must check in with the library supervisor prior to accessing the internet.
5. Therapists may also give permission via the above mentioned permission slip to complete therapy assignments or search for transition placements.
6. Students using the internet may not search any subjects other than those for which the teacher or therapist has signed his or her permission.
7. Students may not access e-mail.
8. Student computer/internet history will be randomly checked by Island View staff.

Since Island View is equipped with a computer lab, lap-top computers are not permitted at Island View. However, students who have academic needs that are best addressed through the use of a personal word processor, NEO 2 by Alphasmart will be permitted. Students may not borrow or lend personal word processors.

I have read and understand the rules and parameters under which my child may use Island View computers, lap-tops, and internet while at Island View. I understand that failure to comply with these rules and parameters will result in serious disciplinary action including but not limited to school suspension, yellow zone, library/computer restriction, and/or loss of phase.

_____ _____ _____

(print name) (sign name) (date)

Parents who want to provide their students with a NEO 2 personal word processor may purchase one from Island View at a cost of $230.00 or they may purchase one directly from Alphasmart at www.alphasmart.com. Parents purchasing a NEO 2 directly from Alphasmart should have it sent to Island View to the attention of Laura Burt. It is recommended that a neoprene sleeve or case be purchased as well in order to protect the unit. Parents purchasing a NEO 2 from Island View must sign below:

I authorize Island View to charge the credit card listed below in the amount of $230.00 for the purchase of one NEO 2 word processor by Alphasmart. I understand that the cost above includes both the word processor and a neoprene sleeve.

Credit Card Information:

Type _____ Number _____ Expiration Date _____

Name (as it appears on card) _____

Signature _____ Date _____

ISLAND VIEW

Dear Parent or Guardian,

We are very pleased to provide you an additional way to connect with your child while at Island View, through the use of *Parent Check In*.

What is Parent Check In?

Parent Check In is a password protected web based site which allows families to keep in touch with their son or daughter's progress by logging onto the site with a password generated by Island View to view pictures of their child involved in daily life, read summaries of treatment progress completed each month by educators, recreation staff, Team Directors, and Primary Therapists, and keep track of upcoming events, such as school grading, Parent Seminars, staff information, and other information of interest to families.

Why Parent Check In?

The old adage that a "picture is worth a thousand words" is particularly true when you have a son or daughter away from home. Being able to also get another "take" about treatment progress through a review can also add to the weekly contact a family has with the Primary Therapist. Plus additional comments from other staff in direct relation to your child; such as teachers, recreational therapists, and Milieu staff.

Does Island View have any concerns?

Parent Check In, in no way, is intended to provide a complete, ongoing, report as to how your child is doing. Families that become overly focused on the minutia of a particular report or picture can become prey to the pitfalls of micromanagement. As you review progress notes about your child, you will note that the progress is rarely linear, nor consistent across the landscape of education, therapy, the milieu, and recreational programming. That variability is how change occurs.

What about the Parent Check In Release of Information Form?

The Parent Check In program has been in place in several Aspen Education Group Programs for many years now and families surveyed about the program have given it very high marks. Families particularly rated the ability to view pictures of their son or daughter in group activities as most helpful, as those pictures told more about their own child than an isolated, individual shot ever could. They realized that their own child's picture could then be viewed by other families, but gave written permission, so as to have that possibility to view group images.

The Release Form states the conditions and limitations under which an image of one family's child can be viewed by another family that has access to the protected website. All families that agree to these conditions to view group pictures also agree to keep the images of other students private. If, for special circumstances, a family does not want to provide a release, Island View will respect that family's wishes and restrict any sharing of their son's or daughter's pictures with other Island View families.

When does the information update?

Tammi Spaulding (tspaulding@ivrtc.com) maintains the Parent Check In site by setting up accounts, taking individual student pictures, and updating web based report forms. Please contact her if you ever have any questions or concerns with Parent Check In. She posts new pictures once a month. The notes on your child from the various other staff will be added for you to view about 6 to 8 weeks after your child admits and then updated once a month as well. The grades are updated at the end for each quarter.

Anything else?

To get this going for you, we really need your Release form signed and turned back into us as soon as possible. You can fax it, attention: Tammi Spaulding at 801-773-0208, email it (to the address listed above) or simply mail it to Island View.

Thank you ever so much for you support,

All our best,

Island View Staff &
Tammi Spaulding
Parent Check-In Coordinator

ISLAND VIEW PARENT CHECK-IN RELEASE OF INFORMATION AUTHORIZATION

On behalf of _____ D.O.B. _____
(Name of Resident) (Date of Birth)

I, _____ authorize Island View Residential
(Name of Parent or Guardian)

Treatment Center to post photographic images of my child,

_____ on the Parent Check-In site maintained
(Name of Resident)

by Island View Residential Treatment Center. I understand that those images may be viewed by other program participants who are authorized and provided a password to access this site. I further understand that images that would be accessed by other program participants would be of group pictures, and that, other information including, but not limited to: name, address, time of admission, etc. would not be included with such images. I further

understand that images of _____ that would
(Name of Resident)

be able to be viewed by other authorized to access the Parent Check-In site would be photographic images of groups of individuals and that images depicting single images of residents are only posted for the private viewing of the sponsors of said resident.

I further understand that photographic images I may view on the Parent Check-In site which include other program participants are confidential, and may not be released to other parties without written permission of said participants.

Date: _____ Signed: _____
(Sponsor – parent or legal guardian)

#1. Printed Name: _____

E-Mail Address: _____

#2. Printed Name: _____

E-Mail Address: _____

Resident's Previous Placement:_____

ISLAND VIEW

Dear Parent/Guardian,

Meningococcal disease is a serious illness, caused by a bacteria. The disease spreads quickly, and within hours of the first symptoms can cause hearing loss, organ damage, and even death. Students living in a dormitory setting have an increased risk of getting meningococcal disease. The Center for Disease Control and Prevention as well as the American Academy of Pediatrics now recommends routine meningococcal vaccinations for certain age groups, as well as those who are high risk. The guidelines recommend the use of the quadrivalent Meningococcal MCV4 Menetra vaccine.

Due to the dormitory setting at Island View, we consider our residents to be in the high risk group. We are therefore offering the Meningococcal MCV4 Menetra vaccine to all residents. The cost of the vaccine is $95. If you would like your child to receive the vaccination, please fill out the attached consent form and remit a check to Island View RTC for the amount of $95, or we are able to charge the credit card we have on file for you. If you do not want your child to receive the vaccination, please complete the attached waiver. We will need to receive either the consent for the vaccination or the waiver that you do not want the vaccination. We highly encourage this vaccination whether it is given at Island View or from some other source. Enclosed you will find additional information regarding the meningococcal vaccine.

If you have any questions please feel free to contact the nursing staff at 801-773-0200 ext. 117.

Island View RTC does not bill insurance for this vaccination charge. Most vaccinations are not covered by insurance. Please feel free to send your receipt and the consent form to your insurance company for consideration if you believe coverage is available. There will be a $15.00 charge to prepare insurance billing forms. Call the business office at Island View if you want this charge billed on a UB-04 billing form.

Sincerely,

Gay Jackson R.N., B.C.
Associate Executive Director
Island View RTC

MENINGOCOCCAL VACCINES

WHAT YOU NEED TO KNOW

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis.

1 What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of **bacterial meningitis** in children 2 through 18 years old in the United States. Meningitis is an infection of the fluid surrounding the brain and spinal cord.

Meningococcal disease also causes blood infections.

About 1,000 - 2,600 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10-15% of these people die. Of those who survive, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people with certain medical conditions, such as lack of a spleen. College freshmen who live in dormitories, and teenagers 15-19 have an increased risk of getting meningococcal disease.

Meningococcal infections can be treated with drugs such as penicillin. Still, about 1 out of every ten people who get the disease dies from it, and many others are affected for life. This is why *preventing* the disease through use of meningococcal vaccine is important for people at highest risk.

2 Meningococcal vaccine

There are two kinds of meningococcal vaccine in the U.S.:

- **Meningococcal conjugate vaccine (MCV4)** was licensed in 2005. It is the preferred vaccine for people 2 through 55 years of age.
- **Meningococcal polysaccharide vaccine (MPSV4)** has been available since the 1970s. It may be used if MCV4 is not available, and is the only meningococcal vaccine licensed for people older than 55.

Both vaccines can prevent **4 types** of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. Meningococcal vaccines cannot prevent all types of the disease. But they do protect many people who might become sick if they didn't get the vaccine.

Both vaccines work well, and protect about 90% of people who get them. MCV4 is expected to give better, longer-lasting protection.

MCV4 should also be better at preventing the disease from spreading from person to person.

3 Who should get meningococcal vaccine and when?

A dose of MCV4 is recommended for children and adolescents 11 through 18 years of age.

This dose is normally given during the routine pre-adolescent immunization visit (at 11-12 years). But those who did not get the vaccine during this visit should get it at the earliest opportunity.

Meningococcal vaccine is also recommended for other people at increased risk for meningococcal disease:

- College freshmen living in dormitories.
- Microbiologists who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has terminal complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

MCV4 is the preferred vaccine for people 2 through 55 years of age in these risk groups. MPSV4 can be used if MCV4 is not available and for adults over 55.

How Many Doses?

People 2 years of age and older should get 1 dose. Sometimes a second dose is recommended for people who remain at high risk. Ask your provider.

MPSV4 may be recommended for children 3 months to 2 years of age under special circumstances. These children should get 2 doses, 3 months apart.

4 Some people should not get meningococcal vaccine or should wait

- Anyone who has ever had a severe (life-threatening) **allergic reaction to a previous dose** of either meningococcal vaccine should not get another dose.
- Anyone who has a severe (life threatening) **allergy to any vaccine component** should not get the vaccine. Tell your provider if you have any severe allergies.
- Anyone who is **moderately or severely ill** at the time the shot is scheduled should probably wait until they recover. Ask your provider. People with a **mild illness** can usually get the vaccine.
- Anyone who has ever had **Guillain-Barré Syndrome** should talk with their provider before getting MCV4.
- Meningococcal vaccines may be given to pregnant women. However, MCV4 is a new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed.
- Meningococcal vaccines may be given at the same time as other vaccines.

5 What are the risks from meningococcal vaccines?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Mild problems

As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a fever.

Severe problems

- Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.
- A serious nervous system disorder called **Guillain-Barré Syndrome** (or GBS) has been reported among some people who received MCV4. This happens so rarely that it is currently not possible to tell if the vaccine might be a factor. Even if it is, the risk is very small.

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever, weakness, or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

  VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

A federal program exists to help pay for the care of anyone who has had a rare serious reaction to a vaccine.

For information about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's National Immunization Program website at **www.cdc.gov/vaccines**
  - Visit CDC's meningococcal disease website at **www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm**
  - Visit CDC's Travelers' Health website at **wwwn.cdc.gov/travel**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf

Meningococcal Meningitis
Vaccination Consent

Resident Name_____

I hereby give my consent for the above named child to be vaccinated against Meningococcal Meningitis. I understand that I have the opportunity to ask any questions about the vaccination and risks involved. I understand that the adverse reactions are usually limited to localized redness or soreness. I understand that my child should not be administered the vaccination if an allergy to the compound is known.

_____ Payment Type
Parents Name (please print) ____ Check ____ Credit Card

CC# _____ Exp _____

_____ _____
Parents Signature Date

Students Name: Last	First	Middle initial	
Age:	Date of Birth:	Phone:	Sex M ☐ F ☐
Address: Street	City	State	Zip
Signature of person to receive vaccine or person authorized to make request: X_____ Date _____			

For clinic / office use only

Date:	Site injected	Nursing staff Administrating vaccine	Vaccine manufacturer and lot number

Meningococcal Meningitis
Vaccination Waiver

Residents Name_____

I understand that the child named above may be at risk of acquiring Meningococcal Meningitis. I have been given the opportunity to have my child vaccinated with the Meningococcal Meningitis vaccination; however, I decline giving my child the Meningococcal Meningitis vaccination at this time.

I understand that by declining this vaccination my child will continue to be at risk of acquiring Meningococcal Meningitis, a serious disease.

_____
Parents Name (please print)

_____ _____
Parents Signature Date

PHONE CARD & PERSONAL SPENDING MONEY

Phone Card

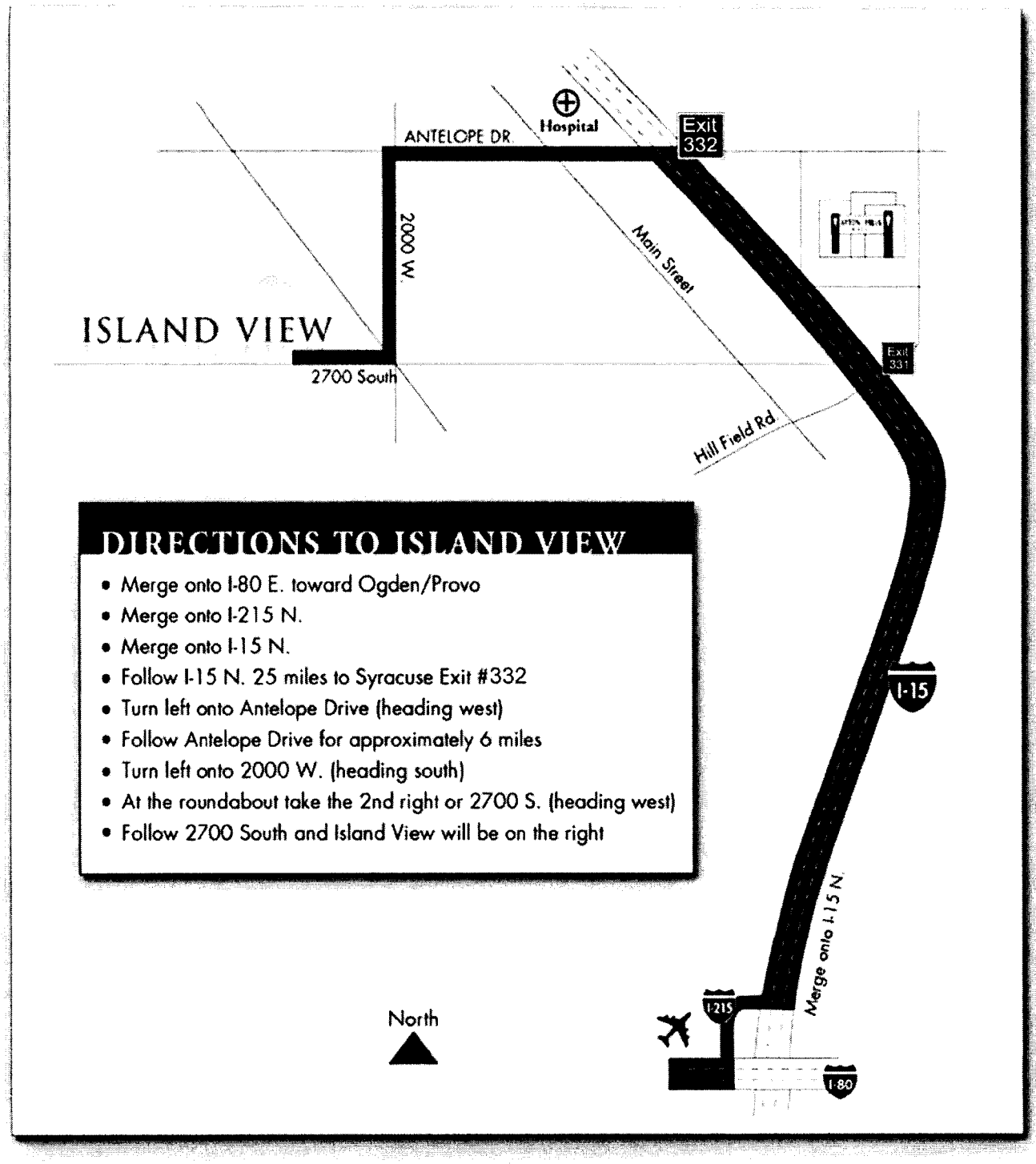
Please provide your child with a pre-paid phone card with 500-800 minutes available on it. These phone cards will be used during weekly phone calls home. Phone calls typically begin two weeks after day of admission, based on therapist recommendation. Please refer to the Parent Manual for duration and call times.

Personal Spending Money

Please also provide your child with a debit card, pre-paid American Express or Visa Gift Card, etc. for their personal spending use (please do not send a bank card). It is the responsibility of the parent to make sure there are funds available. Island View will keep theses cards in our possession at all times except when the resident is paying for something. At the time of purchase, they would be given their card by staff who would then receive it back from them immediately after use. We will also be monitoring what they are purchasing to avoid reckless spending and to teach them financial responsibility.

A suggested balance in these accounts would be $100.00 to $150.00. Residents will only be using their card for Impact and Test Phase outings.

Additionally, residents would not be given this card when they travel on LOA's to avoid temptations to do something foolish. Island View will supply them with cash spending money for when they fly home for visits.



DIRECTIONS TO ISLAND VIEW

- Merge onto I-80 E. toward Ogden/Provo
- Merge onto I-215 N.
- Merge onto I-15 N.
- Follow I-15 N. 25 miles to Syracuse Exit #332
- Turn left onto Antelope Drive (heading west)
- Follow Antelope Drive for approximately 6 miles
- Turn left onto 2000 W. (heading south)
- At the roundabout take the 2nd right or 2700 S. (heading west)
- Follow 2700 South and Island View will be on the right