To Our New Patients:

Woodinville Pediatrics would like to welcome you and your family to our pediatric practice. Established in 1979, we are dedicated to providing pediatric care of the highest quality delivered with compassion, respect and true affection for children and their families. We believe the care of children is best accomplished as a partnership between parents and care providers. Therefore we believe you can have certain expectations of us, and we, in turn can provide the service and quality care you deserve.

We encourage you to read this information thoroughly and ask us any questions you may have. We will work with you to provide information and educate about each stage of your child's growth and development, required immunizations and other health related concerns.

A copy of your child's immunization history, plus medical records from your previous physician are helpful in providing consistent health care to your child. You can make this request at your previous physician's office, or you can use our Request for Medical Records Release form included in this packet.

Office Hours
Monday – Friday: 9:00 AM to 6 PM
Phones are open from 8 AM to 6 PM, closed for lunch from 12 to 1 PM
Saturday (sick visits only): 8:30 AM to 12 PM
Sunday: Closed

After regular office hours, depending on the time, phone calls may be answered by our nurses, the doctor on call, or nurses from Seattle Children's Hospital.

If you have questions regarding billing or insurance, please call (425) 483-5437, option 4.

Well Child Visits:

Please call (425) 483-5437) to schedule a well child visit for your child. Please complete the New Patient Health History form included in this packet.

Well Child appointments may be scheduled up to 3 months in advance. Woodinville Pediatrics follows the American Academy of Pediatrics' recommendations for frequency of well child examinations.

- Children under 3 years of age are seen at 7-10 days, 2 months, 4 months, 6 months, 9 months, 12 months 15 months, 18 months, 24 months, and 30 months.
- Annual exams are recommended for children 3 years to 19 years.

Other special age considerations.

- The 12 month exam must be completed after the child has turned 12 months of age for immunization purposes.
- 4 year old annual physical exams must be completed after the 4th birthday for the immunizations to be recognized for kindergarten enrollment.

Sick Visits

- Call our office when your child is ill to schedule an appointment. We will schedule an appointment for you or offer you an opportunity to speak to one of our specially trained nurses if necessary.
- Give a brief statement of your child's symptoms so the appointment can be scheduled for the appropriate amount of time.
- Woodinville Pediatrics often schedules sick appointments on the same day for urgent issues.
- Each child in the family will need an individual appointment. Please let the scheduler know if you have multiple children needing appointments. Each patient requires additional time and unexpectedly adding patients can cause delays.
- Arriving at the office without an appointment will result in a wait until an appointment time becomes available.
- Urgent concerns should be discussed with our specially trained nurses to determine the appropriate time and location for services.
- Follow up appointments can be scheduled at the desk following your appointment.

<u>With your help, we can better serve your needs:</u>

- Always call for an appointment so we can best schedule you with a provider for your care.
- Please inform us when scheduling if you have more than one child that needs to be seen. Each patient requires additional time and unexpectedly adding appointments can cause delays for other patients.
- Call us in advance if you must cancel your appointment. Your cooperation allows us to use this time to see a another child.
- Be on time for your appointment. We believe your time is valuable, and we strive to see you and your child at the scheduled time. If you are late for an appointment we may ask you to reschedule your appointment. If you are unable to keep your appointment, please call in advance to let us know, allowing us to schedule another patient. Not calling to cancel an appointment may result in termination of services.
- Note the location of your appointment. Some of our providers rotate between offices so our schedulers will confirm the location of the appointment with you.

<u>Triage Nurse Telephone Care</u>

Our nursing staff is trained to handle routine questions and help determine if an appointment is needed or if advice can be given over the telephone. Our nursing staff will also determine if your physician's involvement is necessary in answering the question. The nurses will discuss your questions with your physician between patient examinations and call you back with their instructions. This allows a quick response to your questions. All calls to our nurse line will be returned the same day. If the nurse determines your physician needs to speak to you, the physician will return your call over the lunch hour or at the end of the day. Calls are processed in that way to keep our physicians on time for scheduled appointments.

We appreciate the trust you have placed in us.

Woodinville Pediatrics

**PATIENT'S NAME** _____ **DATE OF BIRTH** _____

**Gender**
__ Male
__ Female
__ Trans MTF
__ Trans FTM
__ Nonbinary/Genderqueer
__ Other: _____
__ Choose not to disclose

**Sex**
__ Male
__ Female
__ Undefined

**Race (Check all that apply)**
__ White __ Black
__ Asian
__ Native Hawaiian/Other Pacific Islander
__ American Indian/Alaskan Native
__ Unknown
__ Other: _____

**Ethnicity**
__ Hispanic
__ Non-Hispanic
__ Unknown
__ Other:
_____

**Preferred Language:**
_____

**Primary Home Language:**
_____

**PATIENT LIVES WITH** _____ **PATIENTS'S CELL:** _____

**SIBLING'S NAME(S) AND DATE(S) OF BIRTH** _____

---

□ **FATHER** □ **MOTHER** □ **GUARDIAN** **HOME PHONE:**

**NAME:** **CELL PHONE:**

**ADDRESS:** **DATE OF BIRTH:**

**CITY/ZIP:** **EMAIL:**

---

□ **FATHER** □ **MOTHER** □ **GUARDIAN** **HOME PHONE:**

**NAME:** **CELL PHONE:**

**ADDRESS:** **DATE OF BIRTH:**

**CITY/ZIP:** **EMAIL:**

---

FATHER'S/MOTHER'S EMPLOYER: WORK PHONE:

FATHER'S/MOTHER'S EMPLOYER: WORK PHONE:

**Emergency Contact** (other than parents) _____ Phone: _____

**Preferred Pharmacy** _____ Phone: _____

**Primary Care Physician** _____

PRIMARY: Insurance Company _____ Effective Date _____ Copay _____

Insured Parent's Name _____ ID # _____

Group # _____ Claims Address _____

SECONDARY: Insurance Company _____ Effective Date _____ Copay _____

Insured Parent's Name _____ ID # _____

Group # _____ Claims Address _____

**By my signature below I acknowledge that I have received the WPHC Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can access my information. A no-show fee of $50 will be added to any no show appointment and/or appointments that are not canceled more than 24 hours before the appointment time.** Please note: In order to control the costs of billing we request that office visits be paid at the time of service unless appropriate insurance information is provided. A finance charge of 1.0% will be added to your account on a monthly basis if your balance is 60 days or older. A minimum finance charge will be $.50 per month on any account older than 60 days. Total annual finance percentage will equal 12% on any account balance that is older than 60 days. (RCW 19.52) **I hereby certify that all of the above information is true. I agree to have medical information released for billing purposes to my insurance carrier and to billing personnel. I agree to pay for any charges not payable by my insurance plan. I furthermore, have read the above and understand that I am responsible for all medical and financial charges.**

**Signed:** _____ **Date:** _____

# PEDIATRIC HEALTH HISTORY

Child's Name: _____ Date of Birth: __/__/_____ Nickname: _____
Mother's Name: _____ Date of Birth: __/__/_____ Occupation: _____
Father's Name: _____ Date of Birth: __/__/_____ Occupation: _____
Siblings' Names and Birthdates: _____

_____

Referred by: _____
**IS YOUR CHILD ON ANY MEDICINES?** _____
**ALLERGIES TO MEDICINES:** _____
**SMOKERS AT HOME?** _____
**IMMUNIZATIONS:** □ up to date □ not up to date Received at: _____
**BIRTH HISTORY** Birthplace: _____ OB :_____
Due Date: _____ Birth Weight: _____ Vaginal or C-Section? _____
Any problems with pregnancy, delivery, or nursery stay? _____
Feeding: □ Breast _____months Any problems? _____
□ Formula ___months Brand: _____ Any problems? _____

**PAST MEDICAL HISTORY:** (please check if the child has a history of)

| | | | |
|---|---|---|---|
| □ Allergies | □ Chickenpox | □ Lazy Eye | □ Injuries |
| □ Asthma | □ Constipation | □ Pneumonia | □ Hospitalizations |
| □ Bladder Infections | □ Chronic Cough | □ Snoring | |
| □ Cavities | □ Eczema/skin problems | □ Seizures | □ Surgeries |
| □ Headaches | □ Ear infections | □ Vision/Hearing Problems | |
| □ Speech Problems | □ Other | | |

**FAMILY HISTORY:** (check if in family)

| | **Relative** | | **Relative** |
|---|---|---|---|
| □ Allergies | | □ High Blood Pressure | |
| □ Asthma | | □ High Cholesterol | |
| □ Diabetes | | □ Early/Sudden Death | |
| □ Heart Attack/Stroke | | □ Cancer | |
| □ Kidney Disease | | □ Other | |

**SOCIAL HISTORY:**
Who does the child live with? _____
If the parents are divorced, what is the custody arrangement? _____
Does anyone besides the parents and siblings live in the house? If so, whom? _____
Who cares for the child while the parents are working? _____
Child's School? _____ Grade: _____ Days missed last year: _____
Any problems at school? _____
Primary source of water at home: □ City □ Well Pets: _____
**PARENT SIGNATURE** _____ Date: _____

Authorization to leave detailed voice mail (answering machine or through Patient Portal) regarding lab results on answering machine.

Child _____ DOB: _____

Child _____ DOB: _____

Child _____ DOB: _____

Child _____ DOB: _____

Child _____ DOB: _____

Child _____ DOB: _____

Child _____ DOB: _____

Patient/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

Woodinville Pediatrics, PLLC
17000 140th Ave NE, Suite 102 Woodinville, WA 98072
Ph: 425-483-5437 Fax: 425-488-4919


# CONSENT FOR MEDICAL CARE FORM

The undersigned hereby authorizes: _____

to obtain medical care for: _____ _____
Name Birthdate

_____ _____
Name Birthdate

_____ _____
Name Birthdate

_____ _____
Name Birthdate

including medical and surgical treatment as ordered by the attending physician, x-ray, examinations, laboratory procedures, and hospital treatment.

_____ _____
Date Signature of Parent or Guardian

Woodinville Pediatrics
**www.woodinvillepediatrics.com**

17000 140th Ave NE, Suite 102
Woodinville, WA 98072
Phone: (425) 483-5437 Fax: (425) 488-4919

# Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Patient's phone #: ( ) _____
**Date of Request:** _____ **Date Needed:** _____

❒ I authorize Woodinville Pediatrics **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

OR

❒ I authorize Woodinville Pediatrics **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

**PURPOSE FOR THIS REQUEST:** (Check one.) ❒ Healthcare ❒ Insurance coverage ❒ Personal ❒ Other ❒ Transfer of Care

**TYPE OF RECORDS REQUESTED:**

❒ Immunization History ❒ All Records ❒Include records submitted to Woodinville Pediatrics.
❒ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

❒ Records for the following date(s)_____
❒ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
❒ Specific information (Select one or more, as applicable)
- ❒ Procedure report ❒ History & physical ❒ Physical Therapy ❒ Laboratory test results
- ❒ X-ray reports ❒ Sports Forms and Medication Forms to Schools:_____
- ❒ Other:_____
(Please describe.)

❒ Entire copy of the record checked above.

**YOU MAY DISCLOSE HEALTH CARE INFORMATION REGARDING TESTING, DIAGNOSIS, AND TREATMENT FOR (INITIAL ALL THAT APPLY):**

❒ HIV (AIDS virus)_____ ❒ Psychiatric disorders/Mental Health_____
❒ Sexually transmitted diseases_____ ❒ Drug/Alcohol use_____

**I understand that:**

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed..
- There may be a charge for the requested records.

**NOTE: Medical records are faxed in cases of medical necessity only.**

Signature of Patient or Representative _____ Date _____

Printed Name of Patient or Representative_____.

Relationship to Patient (if requester is not the patient)_____

**Request expires one year from the date the Authorization is signed.**

# Notice of Privacy Practices
# Woodinville Pediatrics

**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.**

Woodinville Pediatrics respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

## 1. Your health information rights.

The health and billing records we create and store are the property of Woodinville Pediatrics. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:

**Linda Beier**
(425) 483-5437

## 2. Our responsibilities.

**We are required to:**

- Keep your protected health information private.
- Give you this Notice.

- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our office to pick one up, or by visiting our Web site, www.woodinvillepediatrics.com.

## 3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Linda Beier
(425) 483-5437

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Linda Beier at Woodinville Pediatrics. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

## 4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

**Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.**

**For treatment:**

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

**For payment:**

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

**For health care operations:**

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan,
  - Accounting, legal, risk management, and insurance services; and
  - Audit functions, including fraud and abuse detection and compliance programs

**For Health Information Exchange**

Woodinville Pediatrics participates in a health information exchange (HIE). An HIE is an electronic system where hospitals, doctors and other healthcare providers share your health information. Participants in the HIE can access your patient health information as necessary for treatment, payment and healthcare operations. They may also access your information for joint activities with other individuals or organizations to measure quality and improve services.

Your health information is automatically included in the HIE. If you choose not to share your health information through the HIE, you must opt out. To learn more, visit www.seattlechildrens.org/HIE or call 1-866-987-2000 ext. 7-4444 or 206-987-4444.

**For fund-raising communications:**

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

**Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.**

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.

- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law**.**
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

## 5. Uses and disclosures that require your authorization.

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications**: we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

## 6. Web site

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: www.woodinvillepediatrics.com

## 7. Effective date

This Notice is effective as of January 2018.

# Woodinville Pediatrics Billing and Financial Policy

Charges for medical care at Woodinville Pediatrics are based on the complexity of the medical problem, time spent, and our costs. If you have insurance coverage that we are contracted to accept, we will bill them for you as a courtesy. It is your responsibility to know what services are covered and what benefits you have. If your child is covered by two plans, we need this information before your first visit.

**In order to reduce the costs associated with repeated billing we ask the following:**

- *If there is a change in your insurance coverage, please notify the clinic as soon as possible*
- *Please be prepared to show your insurance card at each visit.*
- *If you currently do not have insurance or insurance coverage cannot be verified, payment will be requested at the time of service.*
- *We require our office forms be update **annually** to ensure that we have the correct information for you. Incomplete or incorrect information can result in non-payment from your insurance.*
- *It is the policy of Woodinville Pediatrics to collect certain information for billing purposes. Some of this information is personal and will be kept confidential.*
- *If your insurance is one that we do not bill directly, please ask for a copy of the charge slip after each visit so that you can apply for reimbursement as soon as possible.*
- *If your insurance plan has an office visit co-pay you need to be prepared to pay at each visit. Co-payments not paid at the time of service will be subject to a $25.00 billing fee.*

**WELL CHILD EXAM = PREVENTATIVE CARE:**

*If your child is scheduled for a Well Child Exam, your insurance may call this a Preventative Care Exam. Sometimes your insurance companies have a limit on the number of Well Child Exams that they will cover in a calendar year. We encourage you to contact your insurance and find out what your benefits are. During a Well Child Exam if you have a concern about a **separate** problem, you may incur separate charges for that visit. We are required to follow specific coding laws to communicate to your insurance what was performed during your visit. Your insurance may or may not cover those additional charges and those charges may become your responsibility.*

*With all of the changes in healthcare, we would like to inform our patients that not everything is included under your "preventative care" benefits. Each insurance company has very specific criteria for what they cover under preventative care.*

*If your provider performs additional tests or services during the same visit that are not covered under your preventative benefits, you may have to pay coinsurance, co-pay or your deductible.*

- Financial responsibility for deductibles, co-payments, and services not covered by your insurance rests with you. All balances must be paid upon receipt of the billing statement. If we do not receive full payment on your account within 3 months of the first date of service, your account may be turned over to our collection agency. Your signature indicates that you agree with and understand these policies.
- We understand the unpredictable nature of illness and injury. Please contact us at 425-483-5437 if a major, unexpected medical expense should occur. We are happy to negotiate a payment plan with you.
- If you feel an error has been made on your account, all request for adjustments must be made in writing, as telephone calls with not preserve your rights under the Federal Truth in Lending Regulations. For your convenience, we accept Visa, MasterCard, Checks and cash.

_____ _____

Parent/Guardian Name (please print) Patient Name

_____ _____

Signature of parent/guardian Date