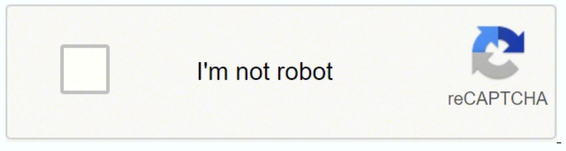


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# Ca full form in medical

## Student Medical Information Form

2015-2016

The purpose of this form is to ensure that the school is aware of any medical conditions the student has that might be affected by, or, that might prevent him/her from engaging in any student activity including P.E. classes, athletic events, field trips, class studies and/or overnight trips. It is assumed by the school that, where necessary, the parents have sought the advice of the student's physician prior to completing this form.

GRADE | TEACHER | STUDENT'S LAST NAME | STUDENT'S FIRST & MIDDLE NAMES | USUAL FIRST NAME

☐ MALE ☐ FEMALE CARE CARD NUMBER _____ DATE OF BIRTH _____ MONTH / DAY / YEAR

PARENT'S MAIN EMAIL ADDRESS _____ CHURCH ATTENDING _____

SECONDARY STUDENT'S EMAIL ADDRESS _____

BIRTHPLACE _____ PRIMARY LANGUAGE SPOKEN _____
CITY / PROVINCE / COUNTRY

| | FATHER | MOTHER |
|---|---|---|
| Parent Name (Last, First): | | |
| Custodian's Name (Homestay) (For International Students) | | |
| Marital Status: | Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Single ☐ Remarried ☐ | |
| Student lives with: | Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ Custodian ☐ Other ☐ | |
| Home address including postal code: | | |
| Home Phone Number: | | |
| Business Phone Number: | | |
| Cellular Number: | | |

**ALTERNATE PERSON TO CONTACT IF PARENT(S) / LEGAL GUARDIAN(S) CANNOT BE REACHED:**

NAME: _____ HOME PHONE # _____ CELL PHONE # _____

DOCTOR'S NAME: _____ DOCTOR'S TEL. # _____

**NOTE:** The responsibility lies with the parent/guardian/custodian to advise the school if any change occurs in the medical or physical condition of the student at any time during the school year.

**Does the student have any medical problems, health concerns, and / or diet restrictions, and / or allergies of which the teacher or school nurse should be aware?** ☐ No ☐ Yes

***My child has the following Medical Condition(s) (check all that apply):***

☐ **Allergies or Asthma** (e.g. specific drugs, certain foods, insect stings, hay fever) Specify: _____
(PLEASE include reaction(s) staff should be aware of)

Is this allergy life threatening? Is any immediate emergency medical care, such as adrenalin, to be given by school staff? ☐ No ☐ Yes
Child carries Epi-pen ☐ No ☐ Yes Inhaler ☐ No ☐ Yes Medical Alert Bracelet ☐ No ☐ Yes

☐ My child has a **medical or physical condition**(s) that may affect his/her participation in the course program or typical school activities (e.g. recent illness or injury, recent hospitalization or surgery, chronic condition(s), phobias, etc.) Specify: _____

☐ My child **requires PRESCRIBED medications** during school hours to be self-administered? ☐ No ☐ Yes
* Administered by staff? ☐ No ☐ Yes Completion of a "*Student Medication Form*" is required for all students who are taking prescribed medications. This additional form may be obtained from any campus office.

The information supplied on this form will be regarded as confidential and shall be made available to the student's current teachers, administration staff and appropriate persons as deemed necessary by School Administration.

**IN CASE OF EMERGENCY:** I hereby give permission to qualified health personnel (the family physician, the school nurse, other outside emergency medical personnel or staff who possess a current first aid certificate) to provide treatment for my child. I accept that any costs associated with the administration of medical treatment shall be borne by the parent or guardian.

## State of California
### Secretary of State

File # _____

**REGISTRATION OF WRITTEN ADVANCE HEALTH CARE DIRECTIVE**
(Probate Code sections 4800-4805)

**IMPORTANT - Read all instructions before completing this form.** This Space For Filing Use Only

**1. CHECK THE APPLICABLE BOX (NOTE: CHECK ONLY ONE BOX):**

☐ New Registration..... For a new registration, check this box and complete the entire form. **There is a $10.00 filing fee for registration of a new directive.**

☐ Amendment..... For an amendment to a previously filed registration form (not the directive), check this box, complete items 3 and 7 and the appropriate section that changed. There is no filing fee.

☐ Revocation Only..... For a revocation (change) of a written advance health care directive that has been registered previously with the Secretary of State or a revocation of your registration, check this box and complete items 3 and 7. There is no filing fee.

☐ Revocation (change) of Prior Directive and New Registration..... For a revocation (change) of a written advance health care directive that has been registered previously and the registration of a new directive, check this box and complete the entire form. **There is a $10.00 filing fee for registering the new directive.**

**2. CHECK THE APPLICABLE STATEMENT(S):**

☐ The written advance health care directive is attached ☐ This serves as notification of intended place of deposit or safekeeping of a written advance health care directive

**3. REGISTRANT'S INFORMATION:**

NAME (LAST) (FIRST) (MIDDLE)

STREET ADDRESS CITY AND STATE ZIP CODE

DATE OF BIRTH PLACE OF BIRTH

**ENTER AT LEAST ONE ITEM:**

a. Social Security Number | b. Driver's License Number and State or Country Issuing | c. Other Identifying Number Established By Law and State or Country Issuing

**4. AGENT INFORMATION** (if any):

NAME (LAST) (FIRST) (MIDDLE)

HOME TELEPHONE NUMBER ( ) WORK TELEPHONE NUMBER ( )

**5. ALTERNATE AGENT INFORMATION** (if any):

NAME (LAST) (FIRST) (MIDDLE)

HOME TELEPHONE NUMBER ( ) WORK TELEPHONE NUMBER ( )

**6. INTENDED PLACE OF DEPOSIT OR SAFEKEEPING OF THE WRITTEN ADVANCE HEALTH CARE DIRECTIVE** (if applicable):

7. SIGNATURE OF REGISTRANT DATE

TYPE OR PRINT NAME OF REGISTRANT

SIGNATURE WITNESS ATTESTED BY SECRETARY OF STATE

State of California—Health and Human Services Agency California Department of Public Health

**Medical Marijuana Program**
**DENIAL APPEALS APPLICATION**
**(Please Print)**

**Instructions:** Use this form to appeal your county's denial of your application for a Medical Marijuana Program Identification Card. This form must be completed by you (the applicant) or by the legal representative specified below in Section 3. Within 30 calendar days from the date you were notified of your application denial, mail this completed form and a copy of your denied application to:

California Department of Public Health
Medical Marijuana Program
Attention: Appeals
MS 5202
P.O. Box 997410
Sacramento, CA 95899-7410

For further information, please contact the Medical Marijuana Program at (916) 552-8600.

**Note:** In order to process this appeal, the California Department of Public Health (CDPH) requires all applicable sections on this form be complete, including the signed declaration. Failure to furnish the authorization in Section 5 and all information required on this form will result in a denial of the appeal.

**SECTION 1: INDICATE BY CHECKMARK BELOW IF THIS APPEAL IS FOR YOURSELF (APPLICANT), YOUR PRIMARY CAREGIVER, OR BOTH**

☐ Patient (applicant) card ☐ Primary caregiver card

**SECTION 2 COMPLETE THE APPLICANT INFORMATION BELOW.**

Name (last, first, middle initial)

Mailing address (number, street) Telephone number ( )

City State ZIP code County of residence

**SECTION 3 COMPLETE THIS SECTION IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.**

Name (last, first, middle initial) Telephone number ( )

Mailing address (number, street) City State ZIP code

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:
☐ I am the conservator for the applicant and I have authority to make medical decisions.
☐ I am an attorney-in-fact under a durable power of attorney for health care.
☐ I am a surrogate decision maker authorized under an advanced healthcare directive.
☐ I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

☐ Parent ☐ Legal Guardian ☐ Other *(please specify)*: _____

**SECTION 4 COMPLETE THIS SECTION IF THE APPEAL IS FOR YOUR PRIMARY CAREGIVER.**

Name (last, first, middle initial)

CDPH 9043 (7/17) Page 1 of 2

FACEY MEDICAL GROUP
An affiliate of PROVIDENCE Health & Services

*EMRN:* *Site:*

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**Attention: Release of Information Department**
**Office** (818) 837-5668 **Fax** (818) 743-5343
**Drop Off Only** 11333 N. Sepulveda Blvd
Mission Hills, CA. 91345

**Type of access requested**: (If selecting more than one (1) option, additional charges may apply)

☐ Paper copy of records ☐ CD Copy ☐ Inspection of records (by appointment only - *allow 5 business days*)
☐ Radiology CD ☐ Transfer Request *(12 months of visits will only be provided)*

**I request access as the** ☐ Patient ☐ Parent/Guardian ☐ Medical Power of Attorney
***(Proof of legal documentation is required)***

Name of Patient (***Please print clearly***) AKA Date of Birth

Address City State Zip Code ( ) Contact Number

Please **SEND** medical information **TO**: Please **REQUEST** medical information **FROM:**
(*Check* ☐ *if same as above*) *(To be used when requesting outside records to come to Facey)*

Name of Person or Entity to Receive Information | Name of Medical Office/Provider

Street Address | Street Address

City, State and Zip Code | City, State and Zip Code

Telephone | Telephone Fax Number

**Duration:** This authorization will expire 12 months from the date signed.

**Revocation Process:** I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Facey Medical Group.

**Right to Copy:** I have a right to receive a copy of the Authorization after I sign it.

**Re-Disclosure Statement:** I understand that once Facey Medical Group discloses my health information to the recipient, Facey Medical Group cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

Rev. 08/21/15

**SEND TO: Scan under ROI/Legal***
**REQUEST FROM: Scan under Outside Records***

## DWC Medical Provider Network Complaint Form 9767.16.5

Reset Form
Print Form

**Person filing compliant** *(Completion of these fields is required)*

First Name | Last Name | E-mail Address | Phone Number

Mailing Address | City | State | Zip Code

Person filing the complaint is *(Check one)*: ☐ Injured worker ☐ Attorney ☐ Provider ☐ Other

**Nature of the Complaint** *(Check all that apply and provide sufficient details of the descriptions below)*

☐ Cannot access MPN website provider listing
☐ Unable to contact Medical Access assistant and/ or MPN contact
☐ Inaccurate MPN listing
☐ MPN notice not provided
☐ Physician or specialist not available in the MPN
☐ Other _____

Employer Name | MPN Name | MPN Identification No.

MPN Contact First Name | MPN Contact Last Name | MPN Contact E-mail | MPN Contact Phone

Date of Initial Written Complaint to MPN *(MM/DD/YYYY)* Imminent Threat to an Injured worker? ☐ Yes ☐ No

**Provide a brief description of the complaint** *(Attach additional pages as needed)*

1. Describe or state the specific sections of the Labor Code or the MPN regulations violated:

2. State when the violation occurred and whether you believe the violation is still occurring:

3. Describe specifically what attempts you have made with the MPN to address the violation:

4. Describe, what, if any, impact there has been on an injured worker because of the violation:

5. What result are you seeking because of the alleged violation:

***Instructions for Formal Complaint Submission to DWC***

Serve the MPN Contact listed above with a copy of this completed form and all supporting evidence; and submit this completed form with all supporting evidence and proof of service on the MPN Contact to: *DWC-MPN Complaints, P.O. Box 71010, Oakland, CA 94612*

DWC Form 9767.16.5 (Rev 8/2014)

Ca 125 full form in medical. Ca full form in cancer. Ca full form in medical billing. Ca bot full form in medical. Ca bm full form in medical. Ca+full+form. Ca rmt full form in medical. Ca full form in medical terms.

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"The integration of Whitehill XML-Transport with CA UNICENTER output management solutions allows customers to effectively exploit their existing IT investments by supporting their evolving information requirements." Unicenter SQL- The station is only one of the complete unicenter database management solutions, which provide a single management environment for heterogeneous databases, database servers and eBusiness applications that support.Last Week announced an alliance that exploited The strengths of the Ebusiness infrastructure of the Global Services Professional of CA Experience and i-Storm's e-commerce expertise to finance, build and manage world-class trade shops with critical back-end systems required by the main companies and retailers of today. "Thanks to the immediate support of CA for this update, we can move forward our plans with the security that we wi have all the management features that we need to make the transition a smooth." CA (Science: abbreviation) Carcinoma; heart attack; cancer; chronological age; Arabinoside cytosine. Abbreviation by cathode. In Thi .. this suit .. All rights reserved. Â © 2002 by McGraw-Hill Companies, Inc.Abbregion for Calcium; Medical dictionary for health and nursing professions Â © Farlex 2012Abreviation for chronological ages; cancer; carcinoma; heart attack; Dictionary soccer.medico for dental professions Â © Farlex 2012q. I'd like to help you, but I think I need a more elaborate question. BHBBB lymphocytes are a type of white globule capable of producing one e e auqca ,eralocitrap ni( elocelom elled otnemivom II .icinu inegitna a airatinummi atsopsir Fundamental for understanding plant processes. Can we give us more details about your illness so that people on the site will be able to give them their advice? Farlex Partner Medical Dictionary Â Â © 2012 Farlex Abbreviation for: caffeicoCaliforniaCanadacancercarbonico anhydrous-carcinomacardiaco arrestcat allergencatecolaminecatodecoeliaco axiscephalic artericerebrale aqueduct-amiloideCertified AcupunctristCertificate AuthorityChalling arthritis (Medtalk-UK) Chemical Abstractschloramphetaminecholic acidcolina-adrenalinchromico acidologic ageActcoen agulazionecartazione dell'aortaCocaina Anonimousacclimatata cold agglutinazionicoeliaca assiscolloide antigen comuneAutoritÃ Competent (medtalk-uk) competition advocatecomputer-assistedconyloma acuminatumanalisi joint (medtalk-uk) contact area ã, (orthopedics) controls assurance (medtalk-uk) cooperative agreementocoracoacromialcororycornu ammonis (ammonÃ ¢ â € ™ s horn) corporate amilacorrective actioncortisone acetateconsiglio acceptocontists Tryside Agency (MedTalk-UK) Analisicartabina Courtship (usually, Ara-C) Cytosine Arabinosydictory Segen medical. Animals adapt to their environment in aspects of anatomy, physiology and behavior. The questions and answers are not approved or recommended and are made available by patients, not by doctors. Ã, chemical symbol, calcium; Cathode (Cathode); oncologist.miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, seventh edition. Edition.

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