Authorization for Treatment

I hereby grant permission to the staff of Student Services/Health Services of Beacon College to render any first aid/health care or emergency treatment to myself (son/daughter). I also grant permission for the above referenced Beacon College staff to arrange health care, emergency treatment or hospitalization at an accredited hospital or medical, psychological or dental care facility when considered necessary.

__________________________________________________________________________  __________
Student Signature                                                                 Date

__________________________________________________________________________  __________
Parent/Guardian (required if student is under 18)                              Date
Verification of health insurance must be submitted upon enrollment and annually for all students, please be sure to put the date on the copy (front and back) of your student’s insurance card.

All medical expenses incurred by students are the responsibility of the individual student, or parent/guardian if student is a minor. It is required that all students carry health insurance.

_When submitting the required forms and documentation to Beacon College personnel, please attach a copy, front and back, of your insurance card._

Please be aware that if you are insured by an HMO (Health Maintenance Organization), you might not be covered for non-emergency services while on campus and outside the plans network. We urge you to contact your plan administrator for details on your coverage. Also, some health plans are PPO’s (Preferred Provider Organization) and require that you use “preferred” clinicians for off campus care that you might require while attending Beacon College. Your plan administrator can provide you with a list of the providers for Leesburg, FL and surrounding areas.

Please let us know right away if you have no insurance coverage, we are able to provide you with insurance options through the American College Student Association (ACSA).

**INSURANCE INFORMATION**

_All students are required to have health insurance – complete information below and a copy of the insurance card (front/back) must be on file._

**Student’s Name:** ________________________________

**Insurance Company:** ____________________________

**Policy Number:** ________________  **Group Number:** ________________

**City/State/Zip:** ____________________________________  **Telephone Number:** ________________

**Policyholder’s Name:** ____________________________  **Employer:** ____________________________

*I hereby assign the benefits of my insurance policy to designated health care providers as appropriate. I understand that I am responsible for all charges that are not paid by that policy. I authorize the release of information needed to my insurance company in order to consider payment of my claim for services rendered. I understand that this assignment and authorization will remain in effect indefinitely or until such time that I give written notice to the contrary.*

**Policyholder signature:**______________________________  **Date:** ____________________________

___Copy of front & back of the insurance card is required!!___
Complete and send this form to the address specified as soon as possible. Completion of this form is necessary to comply with the Florida Statute 1006.69 and the Florida Admin Rule 6C-6.001(5). This form is also available in the Office of Student Services. Please print clearly in black or blue ink. Please complete this form. DO NOT SIMPLY ATTACH THE STUDENT’S CHILDHOOD IMMUNIZATION FORM. Thank you!

Name: 
Last  First  Initial  

Date of Birth: Month  Day  Year

Term/Year for which you are applying or returning:  ☐ Fall  ☐ Spring

A. Immunizations required of ALL students entering Beacon College:

MMR (Measles/Mumps/Rubella)

Dose 1  Dose 2

***Meningitis Vaccine

MM DD YY

***AND Booster IF 1st dose of Meningitis Vaccine was given before 16 years of age:

MM DD YY

Measles (Rubeola)

Dose 1  Dose 2  Titer/Date

OR

Rubella (German Measles)

Titer/Date

OR

Hepatitis B (If Positive HepB surface antibody attach copy of lab results)

Dose 1  Dose 2  Dose 3

MM DD YY

TD (Tetanus/Diphtheria)

TT (Tetanus/ Pertussis)

MM DD YY

B. Immunizations recommended for good health:

Mumps  HPV  Polio (last dose)

MM DD YY

Varicella (Chicken Pox) 2 shots or date of illness

Dose 1  Dose 2  OR  Date of Illness

MM DD YY

Hepatitis A

Dose 1  Dose 2

MM DD YY

C. An official stamp from a doctor’s office, clinic, or health department AND an authorized signature must appear on this form.

Send or fax form as soon as possible to:

Attention: Debra D. Allen  
Beacon College, Student Services  
105 East Main St. Leesburg, FL 34748

E-Fax (800) 313-0359  Phone (352) 638-9701

PLEASE KEEP A COPY FOR YOUR RECORDS
Medical Action Plan & Local Medical Resource List

Merriam-Webster's Desk Dictionary defines transition as “passage from one state or stage to another”. So whether you are entering college for the first time or are a transfer or continuing student, you are experiencing important transitions in your life. You are transitioning to a new place, new responsibilities, new challenges.

To get started:

The MAP must be completed by ALL students.

♦ If you have chronic medical needs, the MAP will help you be better prepared to take responsibility for your health needs.

♦ Continuity of quality medical care is of primary importance to your success in college. Local Medical Resources are provided for your reference on pages 4-7. Please keep those pages for future reference.

Now is the time to prepare yourself. Establish a routine that supports your best health. Keep a calendar to manage your responsibilities: going to class, mentoring, keeping appointments, taking medications as prescribed, eating healthy, studying, sleeping, exercising, socializing, etc. Get involved! There are many workshops, student activities, clubs, and organizations to support your personal wellness.

If you have any questions or concerns or need assistance, please contact me.

Sincerely,

Debra D. Allen RN, MSN, FNP
Director of Student Health
Student Services, Beacon College
(352) 638-9701
dallen@beaconcollege.edu
Planning for success means making the right choices for your health. Now that you are in college and living on your own, it is important that you plan ahead for success. Properly taking medications can make the critical difference between success and failure. Know the name, purpose, side effects, restrictions, interaction precautions, how to take, and how to order and pay for your medications. Keep a calendar, plan ahead so you don’t run out! An interruption in taking medication can sometimes have adverse effects. Take a minute and consider the following questions, answer to the best of your ability.

☐ (check if applicable) I’m not taking any prescribed medications.

How will you make sure you take your medication as prescribed?
☐ Take on my own ☐ Take when reminded by a parent
☐ Take with help of a pill organizer ☐ Take with Lab/Doctor Assistance
Other ______________________________________________________________

How will you make sure you keep a supply of medication to make sure you don’t run out?
☐ Local Pharmacy ☐ Mailed from Home ☐ Mailed direct from Pharmacy
☐ Own Transportation to Pharmacy ☐ College Transportation to Pharmacy
Other ______________________________________________________________

How will you pay for your medication? (Check all that apply, explain if needed)
☐ Parent ☐ Student ☐ Direct through Pharmacy or Insurance

What happens when you don’t take your medication? What happens when you do? ______________________________________________________________

<table>
<thead>
<tr>
<th>Medication</th>
<th>How often to Refill?</th>
<th>Next Date to Refill?</th>
<th>Instructions for taking</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Plan Ahead! Do your homework now and identify medical care professionals close to Beacon College. Schedule appointments in advance and have records forwarded. If using college provided transportation, reserve your time in advance—remember this is a first come first serve basis. Be sure to notify transportation and the doctor if you need to cancel or reschedule an appointment. You may still need to pay if you fail to keep an appointment or to cancel or reschedule with advance notice. *It is especially important for students with chronic illnesses to establish a relationship with a local physician who can monitor their care.*

Medical Care at Home

<table>
<thead>
<tr>
<th>Doctor Name</th>
<th>Type of Practice</th>
<th>Scheduled appointments/ frequency</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Local Medical Care while at Beacon

<table>
<thead>
<tr>
<th>Doctor Name</th>
<th>Type of Practice</th>
<th>Scheduled appointments/ frequency</th>
<th>Phone Number</th>
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<tbody>
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</tbody>
</table>

Signature:_________________________ Date:_______________
LOCAL MEDICAL RESOURCE LIST
PLEASE KEEP PAGES 4-7 FOR YOUR RECORDS

This information is provided as an example of medical service practitioners in the Leesburg area. This list does not represent an endorsement or recommendation by the college, its directors, officers or employees, of any particular medical service provider or practitioner. Before seeking medical assistance be sure to check with your insurance company. Students are responsible for arranging their own medical appointments and transportation. Limited transportation is available on a first come basis during weekday business hours and is limited to necessary medically related issues; contact the Transportation Coordinator to schedule transportation. There may be a minimal fee and service may be limited to a 20 mile radius. Students and/or parents are responsible for payment of all medical expenses.

Family Physicians

Physicians' Referral
(352) 323-1000

Leesburg Family Medicine
802 East Dixie Ave., Leesburg, FL 34748
(352) 787-1324

Dr. Rolando Menendez
608-A South 9th St., Leesburg, FL 34748
(352) 365-2221

Leesburg Community Health Center
225 N. 1st Street, Leesburg, FL 34748
(352) 360-0490

Lake County Health Department
14 N. Eustis Street, Eustis, FL 32726
(352) 589-6424

Lakeview Internal Medicine, P.A.
101 S. 11th Street, Suite 4
Leesburg, FL 34748
(352) 460-4004

Psychiatrists

Advanced Behavioral Health Center
Dr. Luis Torres
1799 Salk Ave., Tavares, FL 32778
(352) 742-8300

Dr. Hector Deleon
221 N. Joanna Ave., Tavares, FL 32778
(352) 742-8300

Psychologists

NCS Counseling and Development Center
Dr. Nadine Vaughan
101 East Maud St., Tavares, FL 32778
(352) 253-9348

Central Florida Psychological Consultants
Dr. W. Steven Saunders
1114 W. Dixie Ave., Leesburg, FL 34748
(352) 365-2243

Lake Center of Hope
Dr. Ludy Ungson
33057 Professional Drive, Suite 102
Leesburg, FL 34788
(352) 787-0081

Counselors

Ms. Peggy Keene
301 N. Baker St. Suite 213
Mount Dora, FL 32757
(352) 742-0069

Associates for Counseling Services, P.A.
217 N. 14th Street, Leesburg, FL 34748
(352) 365-1098
**LOCAL MEDICAL RESOURCES**

**Cardiologists**

Florida Heart & Vascular Center
511 Medical Plaza Drive #101
Leesburg, FL 34748
(352) 728-6808

Lake Heart & Medical Center
732 N. 3rd St., Leesburg, FL 34748
(352) 728-2532

**Neurologists**

Lake Neurology Clinic
Dr. Marilyn Patterson
608 S. 9th Street, Leesburg, FL 34748
(352) 360-1122

Neurological Associates of Lake County
601 Medical Plaza Drive, Leesburg, FL 34748
(352) 787-7611

**Allergists/Asthma**

Dr. Thomas Shen
8245 CR 44 Leg A, Leesburg, FL 34748
(352) 314-2929

**Dentists**

Main Street Dentists
606 W. Magnolia Street, Leesburg, FL 34748
(352) 787-4800

The Dental Touch
918 East Dixie Ave.
Leesburg, FL 34748
(352) 728-8300

**Oral Surgeon**

Dr. Ed Blanton
2149 US Hwy 441, Leesburg, FL 34748
(352) 728-6600

Central Florida Oral & Maxillofacial Surgery
265 Hatteras Ave., Clermont, FL 34711
(352) 242-5331

**Ear, Nose, & Throat**

Lake Ear, Nose, Throat & Facial Plastic Surgery Associates
Medical Plaza 901, 601 E. Dixie Ave. Leesburg,
FL 34748
(352) 728-2404

**Dermatologists**

Lake Dermatology
1132 E. North Blvd., Leesburg, FL 34748
(352) 365-6650

Advanced Dermatology
1816 Salk Ave.
Tavares, FL 32778
(352) 343-2461

Dr. Michel Snyder
608 S. 9th Street, Leesburg, FL 34748
(352) 787-4532

**Chiropractors**

Lake Chiropractic Clinic
1235 W. Dixie Ave., Leesburg, FL 34748
(352) 787-2785

Leesburg Chiropractic Center
1107 W. North Blvd. #23, Leesburg, FL 34748
(352) 787-4500
LOCAL MEDICAL RESOURCES

Women’s Health

Advanced OB/GYN Associates
1414 West Main St.
Leesburg, FL 34748
(352)728-3898

Leesburg Community Health Center
225 N. 1st Street, Leesburg, FL 34748
(352) 360-0490

Nutritionists

Jeff Whitman
914 N. 14th St., Leesburg, FL 34748
(352) 365-6477

David Frerking
915 E. Alfred Street, Tavares, FL 32778
(352) 343-9275

Wellness

LRMC Wellness Center
700 N. Palmetto St.
Leesburg, FL 34748
(352) 323-5640

Labs

Quest Diagnostics
Patient Service Center
101 South 11th St., Suite 2
Leesburg, FL 34748
(352) 787-5721
Hours: Monday-Friday
7:00 a.m. to 4:00 p.m.

Lab Corp of America
601 E. Dixie Ave. Suite 804
Leesburg, FL 34748
(352) 319-8013
Hours: Monday-Friday
7:00 a.m. to 4:00 p.m.

Hospitals

Leesburg Regional Medical Center
600 East Dixie Drive
Leesburg, FL 34748
(352) 323-5762

Florida Hospital—Waterman
1000 Waterman Way
Tavares, FL 32778
(352) 253-3600

Radiology

Advanced Imaging Center
211 N. First St.
Leesburg, FL 34748
(352)435-0111

Lake Medical Imaging
801 E. Dixie Ave
Leesburg, FL 34748
(352)787-5858

Pharmacies

Burry's Pharmacy
500 Webster St., Leesburg, FL 34748
(352) 787-3787

STARx Pharmacy
802 East Dixie Ave., Leesburg, FL 34748
(352) 323-9555

Publix Pharmacy
Hwy 27 (14th Street), Leesburg, FL 34748
(352) 787-0664

CVS/Pharmacy
1235 N. 14th Street, Leesburg, FL 34748
(352) 787-7800

Walgreens
901 S. 14th Street, Leesburg, FL 34748
(352) 787-3506/Prescriptions
LOCAL MEDICAL RESOURCES

**Cont. Pharmacies**

McHills Pharmacy  
4120 Corley Island Rd.  
Leesburg, Florida 34748  
(352)460-4057  
Dr. Martin Ugwu

Express Pharmacy Leesburg  
1450 N. Boulevard East  
Leesburg, Florida 34748  
(352)460-0542

**Walk-In Care Centers**

Central Florida Express Care  
501 North Blvd.  
Leesburg, FL 34748  
(352) 431-3743

STARx Urgent Care  
802 East Dixie Ave., Leesburg, FL 34748  
(352) 323-9555

Express Care of Leesburg  
2500 Citrus Blvd.  
Leesburg, FL 34748  
(352) 728-5335

US Health Works  
210 South Lake St Suite 4  
Leesburg, FL 34748  
(352)787-4977

Lake Regional Urgent Care  
8404 U.S. Highway 441  
Leesburg, FL 34788  
(352)315-8881
Medical History & Emergency Contact Form

Personal Data – please print legibly in blue or black ink.
Name: ___________________________ ___________________________ ________ Male □ Female □

Date of Birth: ___________________________ ___________________________ ___________________________
Month Day Year Height: ___________ Weight: ___________

Email: ___________________________

Cell Phone: ___________________________

Will reside in campus housing? □ YES □ NO
Year/Term: 20____ Spring Fall

Emergency Contact: ___________________________

Phone 1: ___________________________
Phone 2: ___________________________

Personal Medical History – please print legibly in blue or black ink.
Do you have any allergies? □ Yes □ No If yes, please specify. Include medications, insect bites, environmental factors and food allergies.

Do you smoke? □ Yes □ No Do you use other tobacco products? □ Yes □ No

Do you consume alcohol? □ Yes □ No

Please indicate below if you are being treated or have been treated in the past for any of the following and indicate the year.

□ ADD/ADHD
□ Alcohol/Drug Dependency
□ Anemia, Blood Disease
□ Anxiety/Depression
□ Arthritis, Joint Disease, Bone Disease
□ Asperger's Disorder
□ Asthma
□ Bipolar Disorder
□ Blood Clot/Phlebitis
□ Cancer
□ Chicken Pox
□ Diabetes (indicate type)
□ Digestive Disorder

□ Epilepsy, Seizures (if yes read Beacon College Seizure Protocol & complete Seizure Action Plan)
□ Head Injury
□ Heart Murmur/Disease
□ Hepatitis
□ High Blood Pressure
□ Hypoglycemia (low blood sugar)
□ Lyme Disease
□ Malaria
□ Migraines
□ Rheumatic Fever
□ Schizophrenia
□ Thyroid Disease
□ Tuberculosis

Personal Physician: Name ___________________________ Address ___________________________ Phone ___________________________

Are you currently under the care of any clinical practitioner for any other medical conditions? □ Yes □ No

Medications (include birth control, vitamins, herbs and dosage, times/day, a.m./p.m., etc.): ___________________________

List operations and/or hospitalizations (include reason and year): ___________________________

Mental Health History: Please answer all questions

Have your academic and/or work activities ever been interrupted because of mental health or emotional problems? □ No □ Yes

Have you ever been treated with any medication for psychiatric reasons? Please explain: ___________________________

Have you ever been hospitalized for mental or emotional problems? Please explain: ___________________________

Signature: ___________________________ Date: ___________________________
TO THE EXAMINER: Please review the student’s history and complete the following Physical Examination form. Please comment on all positive findings and be sure all information is complete.

Name: __________________________      Sex: □ Male □ Female  Date of Birth: ___/___/___

Blood Pressure: ________ Pulse: _______ Weight: _________ Height: ___________

Visual Acuity: OD 20/_____ OS 20/_____ Corrective Lenses: _________________________

ANY ABNORMALITIES OF:

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<tr>
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<th>Y</th>
<th>N</th>
<th>Explain</th>
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<tr>
<td>Skin</td>
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<tr>
<td>Head, Eyes, Ears, Nose, Throat</td>
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<tr>
<td>Neck, Thyroid</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Heart</td>
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<td>Abdomen</td>
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<td>Genitals</td>
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<td>Hernia</td>
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<td>Extremities/Joints</td>
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<td>Neurological</td>
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<tr>
<td>Mental Status</td>
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</tbody>
</table>

List Current Medications: □ N/A ______________________________________________________

List Allergies (Medications/Environmental/Food): ______________________________________

Surgical History: _________________________________________________________________

Mental Health History: ____________________________________________________________

Full unlimited athletic participation: □ Yes □ No Explain: _____________________________

Date ____________   Medical Providers Signature/Stamp: _______________________________
TUBERCULOSIS RISK QUESTIONNAIRE

Student Name ___________________________ Date of Birth ___________________________

1. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?

   YES  NO

2. Were you born in one of the countries listed below?

   YES  NO

3. Have you traveled or lived for more than one month in one or more of the countries listed below?

   YES  NO

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*


<table>
<thead>
<tr>
<th>Afghanistan</th>
<th>Congo</th>
<th>Kazakhstan</th>
<th>Niue</th>
<th>Thailand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>Côte d'Ivoire</td>
<td>Kenya</td>
<td>Northern Mariana Islands</td>
<td>Timor-Leste</td>
</tr>
<tr>
<td>Angola</td>
<td>Democratic</td>
<td>Kiribati</td>
<td>Pakistan</td>
<td>Togo</td>
</tr>
<tr>
<td>Armenia</td>
<td>Democratic</td>
<td>Lao People's</td>
<td>Palau</td>
<td>Turkmenistan</td>
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<tr>
<td>Azerbaijan</td>
<td>Djibouti</td>
<td>Latvia</td>
<td>Panama</td>
<td>Tuvalu</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Dominican</td>
<td>Lesotho</td>
<td>Papua New Guinea</td>
<td>Uganda</td>
</tr>
<tr>
<td>Belarus</td>
<td>Ecuador</td>
<td>Libyan</td>
<td>Peru</td>
<td>Ukraine</td>
</tr>
<tr>
<td>Belize</td>
<td>Equatorial Guinea</td>
<td>Lithuania</td>
<td>Philippines</td>
<td>United Republic of</td>
</tr>
<tr>
<td>Benin</td>
<td>Eritrea</td>
<td>Lithuania</td>
<td>Republic of Korea</td>
<td>Uzbekistan</td>
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<tr>
<td>Bhutan</td>
<td>Ethiopia</td>
<td>Madagascar</td>
<td>Republic of Moldova</td>
<td>Vanuatu</td>
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<tr>
<td>Bolivia</td>
<td>Gabon</td>
<td>Malawi</td>
<td>Romania</td>
<td>Viet Nam</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>Gambia</td>
<td>Malaysia</td>
<td>Russian Federation</td>
<td>Yemen</td>
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<tr>
<td>Botswana</td>
<td>Georgia</td>
<td>Mali</td>
<td>Rwanda</td>
<td>Zambia</td>
</tr>
<tr>
<td>Brazil</td>
<td>Ghana</td>
<td>Marshall Islands</td>
<td>Sao Tome and Principe</td>
<td>Zimbabwe</td>
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<tr>
<td>Brunei Darussalam</td>
<td>Greenland</td>
<td>Mauritania</td>
<td>Senegal</td>
<td>Thailand</td>
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<tr>
<td>Burkina Faso</td>
<td>Guam</td>
<td>Micronesia</td>
<td>Sierra Leone</td>
<td>Timor-Leste</td>
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<tr>
<td>Burundi</td>
<td>Guatemala</td>
<td>Mongolia</td>
<td>Solomon Islands</td>
<td>Togo</td>
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<tr>
<td>Cambodia</td>
<td>Guinea</td>
<td>Morocco</td>
<td>Somalia</td>
<td>Turkmenistan</td>
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<tr>
<td>Cameroon</td>
<td>Guinea-Bissau</td>
<td>Mozambique</td>
<td>South Africa</td>
<td>Tuvalu</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>Guyana</td>
<td>Myanmar</td>
<td>South Sudan</td>
<td>Uganda</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>Haiti</td>
<td>Namibia</td>
<td>Sri Lanka</td>
<td>Ukraine</td>
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<tr>
<td>Chad</td>
<td>Honduras</td>
<td>Nepal</td>
<td>Sudan</td>
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<tr>
<td>China</td>
<td>India</td>
<td>Nicaragua</td>
<td>Suriname</td>
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<tr>
<td>China, Hong Kong SAR</td>
<td>Indonesia</td>
<td>Niger</td>
<td>Swaziland</td>
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</table>

- If you answered **YES** to any of the above questions, you are considered “high-risk” and are required to submit documentation of recent PPD testing on the Immunization form. PPD testing should be within the last 12 months.

If the Mantoux PPD test is positive (≥ 10mm), you must submit a copy of a chest x-ray report in English dated within the last 6 months.

Please note: If you have had a positive tuberculin skin test in the past, you do not need another test. Please note prior treatment completed.

Name: ___________________________ Date: ___________________________