School-based Health Centers

School-based health centers make getting medical care as simple as walking down the hall!

What are the advantages of school-based health centers?

- Your child will be seen by a specially trained pediatric provider.
- You do not have to take time off work to visit a doctor’s office.
- Your child will spend less time out of the classroom and away from school.

The School-based Health Center of the Bradshaw Institute for Community Child Health & Advocacy is a medical clinic within your child’s school that offers a range of health care services:

- On-site testing and treatment for illnesses such as strep throat and flu.
- Screening for mental health and emotional issues.
- Check-ups for chronic conditions like asthma and ADHD.
- Referrals to medical specialists and community resources
- Telehealth, which improves access and allows your student to be seen five days a week.

Complete the attached paperwork today so your child can be seen throughout the school year.

For more information, ask your school nurse, visit www.ghschildrens.org/community-pediatrics or contact Melinda Lavallee-Turner, Community Pediatrics program coordinator at the Bradshaw Institute for Community Child Health & Advocacy, at 864-454-2341.

Note: GHS and Palmetto Health have joined to become Prisma Health.
Meet Our Medical Leadership Team

Dr. Kerry Sease is a graduate of the University of South Carolina School of Medicine Columbia. She completed her pediatric training with Greenville Health System and went on to continue her training at the Children’s Hospital of Pittsburg where she completed a General Academic Pediatric Fellowship. During her fellowship, she also earned her Masters of Public Health (MPH) from the University of Pittsburg School of Public Health. Dr. Sease currently serves as the Medical Director for Prisma Health Children’s Hospital—Upstate’s Bradshaw Institute for Community Child Health & Advocacy.

Holly Bryan (MSN, PNP-BC) received her undergraduate nursing degree from the University of North Carolina at Chapel Hill and completed her Masters in Nursing/Pediatric Nurse Practitioner (PNP) education at the University of Alabama at Birmingham. Holly has worked as a Pediatric Nurse Practitioner in pediatric Hematology/Oncology, pediatric Gastroenterology, and general Pediatrics. Holly currently serves as the Primary Pediatric Nurse Practitioner in Prisma Health Children’s Hospital—Upstate’s School-based Health Centers.
Prisma Health Children’s Hospital-Upstate School-based Health Center Enrollment Forms

We are excited to offer your child medical care this school year through Prisma Health Children’s Hospital-Upstate’s School-based Health Center. A Prisma Health pediatric medical provider will be present in your child’s school at least one day a week. If the medical provider is not physically present and your child is sick, he or she can still be seen through telemedicine. Telemedicine allows a nurse and the medical provider to communicate via video equipment while your child is in the health room. A limited exam can be completed and diagnosis and treatment will be provided for your child. In order for your child to be seen by the Prisma Health medical provider, in clinic or via telemedicine, you will need to complete the following four forms located in this folder. Please fill out all highlighted areas on each form.

- Consent and Authorization-UMG
  - Gives the Prisma Health medical provider permission to provide medical care to your child in the School-based Health Center.

- Over the Counter Medication Form
  - Provides information about your child’s medication history and allows the Prisma Health medical providers to give over the counter medications in clinic if necessary.

- Consent for Release of Education Records and Information
  - Allows the school to share information with the Prisma Health medical team in order to provide your child with the best possible medical care.

- Patient information sheet
  - Provides Prisma Health medical provider with necessary patient demographic and billing information.

If you need any assistance with completion of the above forms contact your school nurse or a member of the School-based Health Center team.
PERMISSION TO TREAT - UMG

GREENVILLE HEALTH SYSTEM

STUDENT NAME: __________________________

DATE OF BIRTH: __________________________

SCHOOL: __________________________

GENERAL PERMISSION TO TREAT:
I am the Patient named above (or the person authorized by law to make decisions for the Patient). I give permission to Greenville Health System ("GHS") and the physicians, health care providers, staff and outside companies providing services at GHS, to order and provide routine health care services, including diagnostic, laboratory, and treatment procedures, that in the judgment of the provider(s) are necessary to diagnose and treat my symptoms or conditions.

Diagnostic and laboratory procedures that may be ordered for me (and/or my newborn infant) include (but are not limited to) testing for diseases such as Human Immunodeficiency Virus (HIV), Hepatitis, any other diseases categorized as contagious or sexually transmitted diseases, and Methicillin-resistant Staphylococcus Aureus (MRSA). I understand that I can discuss these tests with my health care provider and can tell my health care providers (nurses, technicians and physicians) if I do not want to be tested for any one or all of these diseases. If I do not refuse these tests, I may be tested and those results will be included in my medical record. If the test results are positive, the results will be shared with me. If a health care worker comes in direct contact with my blood or body fluids, I understand that South Carolina law allows my blood to be tested without my consent for the Hepatitis B virus, Hepatitis C virus, or HIV to determine whether or not the viruses are present. The results of the test(s) will be made available to me and to the health care worker who was exposed.

Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment.

HEALTHCARE PROVIDERS: I understand that doctors who are providing services at GHS are members of the GHS medical staff, but they may not be employees or agents of GHS. Some providers, including doctors, physician assistants, nurse practitioners and certified nurse midwives, are non-employed, independent providers. I understand that GHS is not responsible for any acts or omissions by a provider who is not an employee or agent of GHS. I also understand that GHS is a medical teaching institution and that students and residents may be involved in my care with appropriate required supervision.

TELEMEDICINE: Health care services may be provided via telemedicine which means an image, video recording and/or audio of me may be used to allow health care providers at different locations to see me on a computer screen or view my medical records. Telemedicine may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: my medical records, medical images, live two-way audio and video, output data from medical devices and sound and video files. Electronic systems used will incorporate network and software security protocols to help protect the confidentiality and integrity of patient identification and imaging data. Prior to use of telemedicine services, a provider will discuss this with the patient.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS:
If I have insurance, I agree to assign to GHS any and all rights including money from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, workers’ compensation benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of GHS), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self-funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to doctors who are not employed by GHS, any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at GHS (such as pathologists and other private doctors). I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of Patients; plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Affairs.

THIS IS A THREE PAGE DOCUMENT

INITIALS OF PATIENT/LEGALY AUTHORIZED REPRESENTATIVE

100797 (4/18)
Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate GHS as my authorized representative and grant to GHS the authority to act on my behalf in pursuing and appealing a benefit determination under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary of the plan description.

**MEDICARE PATIENTS:** If I am eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

**FINANCIAL AGREEMENT:** I understand that I am obligated to pay my account according to the regular rates and terms of GHS, except for those services, provided in accordance with a clinical research trial, which are specifically identified in writing as services for which I am not obligated to pay. I hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, I authorize GHS to apply the over payment to any other account(s) for which I am responsible with any entity of GHS, including GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity, whether now or later is a part of GHS. If there is no other outstanding accounts for which I am responsible, the payment will be posted to the intended account and a refund processed accordingly. I understand that GHS may obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.

**CONTACTING PATIENTS:** I give permission to be contacted by GHS and/or GHS Partners in Health, Inc. and its employees and outside contractors including debt collection companies through any contact information that I have provided to GHS and/or GHS Partners in Health, Inc. for any purposes related to my medical diagnosis, treatment, community service, unsolicited advertisements, marketing, payment for services, debt collections for bills owed, or for any other purpose related to treatment, payment or business operations. (This permission to contact also applies to outside independent companies and doctors and their employees who provide services in or for GHS facilities.) I give my permission to GHS contacting me in ways that may cause me to be charged a fee, and I will be responsible to pay the fees related to cell phone, home phone, work phone, text message, email or fax usage for contacts made by GHS. I give permission to GHS using automated dialing and/or artificial or prerecorded voice messages when contacting me by cell, home or work phone, paging service, specialized mobile radio service, radio common carrier service, or by or through any other service for which the called party will be charged a fee for the call or a fee for the data used or a fee for the minutes used for any reason listed above. I give permission to be contacted by SMS text message for appointment reminders. Such notices are unencrypted and are, therefore, considered unsecure communications but they will not include any clinical information. I understand that this permission to contact will allow GHS to call me using phone numbers that I may have listed on National or State Do-Not-Call Registry(s).

**DISCLOSURE/USE OF HEALTH INFORMATION:** I understand that uses and disclosures of my personal and health information are described in the GHS Notice of Privacy Practices (NPP). These include providing information to other providers through various methods, including to the GHS Health Information Exchange (HIE), for continuing care, to an insurance company or other payor (such as Medicare) to process payment, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I acknowledge by signing below that I have had the opportunity to receive a copy of the NPP. I also consent to the following:

- **Mother/Baby Record.** If I am getting care that may affect a baby that I am carrying or have delivered, I consent to any information being put into the baby's medical record, including, but not limited to, psychiatric, drug/alcohol abuse, or any information about testing/treatment for HIV/AIDS, syphilis, communicable, venereal, or other infectious diseases, or my medical history.

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**THIS IS A THREE PAGE DOCUMENT**

**CHART COPY**

Permission to Treat - UMG

100797 (4/18)
PERMISSION TO TREAT - UMG

- Consent to Use and Disclose Sensitive Information. I specifically consent to any and all of my personal or medical information being used and disclosed to my health care providers and through the HIE as noted in the NPP, including (but not limited to):
  - Information about genetic testing, such as lab tests of my DNA or chromosomes conducted to discover diseases or illnesses of which I am not showing symptoms at the time of the test and that arise solely as a result of defects or abnormalities in genetic material.
  - Information showing (1) whether I have been diagnosed as having AIDS; (2) whether I have been or are currently being treated for AIDS; (3) whether I have been infected with HIV; (4) whether I have submitted to an HIV test; (5) whether an HIV test has produced a positive or negative result; (6) whether I have sought and received counseling regarding AIDS; and (7) whether I have been determined to be a person at risk of being infected with AIDS.
  - Information about suspicion of, diagnosis for, or treatment of mental illness or developmental disability.
  - Information about communicable, venereal, infectious and/or sexually transmitted diseases (ex. HIV/AIDS, Hepatitis, Syphilis, Tuberculosis, Chancroid, Gonorrhea, etc.).
  - Information about pregnancy, prevention of pregnancy (including birth control); child-birth; abortions.
  - Information about diagnosis, treatment, detoxification or rehabilitation for alcohol or drug use or abuse.

PATIENT RIGHTS: I understand that I have certain rights and responsibilities that are set forth in the Patient Rights and Responsibilities that are posted and available as a handout.

PHOTOGRAPHING AND VIDEOTAPING: I understand that GHS may take photographs, video or audio recordings of me only in the course of and for purposes of my treatment, and that GHS will only use any photographs, videos or audio recordings internally for diagnosing, treating or for healthcare operations.

PERSONAL VALUABLES/BELONGINGS: I agree not to bring dangerous items onto GHS property. GHS is NOT responsible for personal property. GHS is a NO SMOKING facility.

Any alterations to the content of any of the conditions above are void and will not change the conditions as stated.

I understand the practice of medicine and the security of personal health information is not an exact science, that not all risks can be eliminated and that no guarantees have been made to me.

I SIGN BELOW ACKNOWLEDGING THAT I HAVE READ, ASKED QUESTIONS AND UNDERSTAND AND AGREE TO ALL 3 PAGES OF THIS FORM.

DATE/TIME SIGNATURE OF WITNESS SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE

DATE/TIME SIGNATURE OF SECOND WITNESS (NECESSARY ONLY FOR TELEPHONE CONSENT) PRINT NAME AND RELATIONSHIP IF OTHER THAN PATIENT

THIS IS A THREE PAGE DOCUMENT

CHART COPY

Permission to Treat - UMG

100797 (4/18)
**Patient Information**

(Please print)

**Full Legal Name:**

Last  First  Middle

**Preferred Name:**

**Sex:**  □ Male  □ Female

**Ethnicity:**

- [ ] Hispanic/Latino
- [ ] Non-Hispanic/Non-Latino
- [ ] Refuse/Decline

**Date of Birth:**

Month/Day/Complete Year

**SS#:**

**Primary Care Physician:**

**Preferred Pharmacy Name:**

**Phone Number:**

**Marital Status:**

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed
- [ ] Life Partner
- [ ] Legally Separated

**Race:**

- [ ] Caucasian (white)
- [ ] American Indian
- [ ] African American (black)
- [ ] Other
- [ ] Asian Oriental
- [ ] Biracial
- [ ] Unknown

**Home Address:**

City:

State:  Zip:

Mail to Address:

City:

State:  Zip:

County:  Home Phone:  Cell Phone:  E-mail:

**Preferred language:**

**Veteran:**

- Yes  No  Unknown

**Religion:**

**Guarantor Information** (If guarantor is Self, skip to Emergency Contact)

Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

**Name:**

Last  First  Middle  Home Phone:  Cell Phone:

**Date of Birth:**

**SS#:**

**City:**

State:  Zip:

Mail to Address:

City:

State:  Zip:

Emergency Contact (Pediatric Patients please list someone other than parent(s)/guardian)

**Primary Contact**

Name:  Home Phone:

**Patient Relation to Emergency Contact**:  Cell Phone:

**Secondary Contact Name**:  Home Phone:

**Patient Relation to Emergency Contact**:  Cell Phone:

**Employment**

**Patient Employer:**

**Address:**

City:

State:  Zip:

**Work Phone:**

**Ext:**

Employment Status:

- [ ] Full-Time
- [ ] Part-Time
- [ ] Student Part-Time
- [ ] Retired Date
- [ ] Self Employed
- [ ] Active Military
- [ ] Disabled
- [ ] Not Employed
- [ ] Student Full Time
- [ ] Unknown

**Parent/Guardian & Immediate Family Information** (Pediatric Patients Only)

**Mother (If the address, phone numbers and employer information is the same as guarantor, please indicate same.)**

Full Name:  Nickname:

SS#:  Date of Birth:  Month/Day/Complete Year

Home Address:  City:

State:  Zip:

(If different from patient)  Home Phone:

Employer:  Work Phone:

**Father (If the address, phone numbers and employer information is the same as guarantor, please indicate same.)**

Full Name:  Nickname:

SS#:  Date of Birth:  Month/Day/Complete Year

Home Address:  City:

State:  Zip:

(If different from patient)  Home Phone:

Employer:  Work Phone:
(Pediatric Patients Only) Brothers, Sisters & Other Family Members

<table>
<thead>
<tr>
<th>Full Name</th>
<th>M or F</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Lives with child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

☐ Check here if no insurance. And, skip to Authorization (below).

Accident Information
Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.)  ☐ Yes ☐ No
Type of Accident: __________________________ Date of Accident: __________________________ County of Accident: __________________________

Primary Insurance Information
Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber’s Name on card: __________________________ Date of Birth: __________________________ Month / Day / Complete Year

Patient Relationship to Subscriber: __________________________ Sex: ☐ Male ☐ Female
If address and phone number is same as patient, please indicate same.
Address: __________________________
City, State, Zip: __________________________
Employer: __________________________
Home Phone: __________________________ Ext.: __________________________
Work Phone: __________________________ Ext.: __________________________

Insurance Co. Name: __________________________ Policy/Cert #: __________________________ Group No.: __________________________
Subscriber Status: ☐ Full-Time ☐ Part-Time ☐ Self Employed ☐ Active Military ☐ Student Full Time
☐ Student Part-Time ☐ Retired Date __________ ☐ Disabled ☐ Not Employed

Effective Date: __________________________

Secondary Insurance Information
SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber’s Name on card: __________________________ Date of Birth: __________________________ Month / Day / Complete Year

Patient Relationship to Subscriber: __________________________ Sex: ☐ Male ☐ Female
If address and phone number is same as patient, please indicate same.
Address: __________________________
City, State, Zip: __________________________
Employer: __________________________
Home Phone: __________________________ Ext.: __________________________
Work Phone: __________________________ Ext.: __________________________

Insurance Co. Name: __________________________ Policy/Cert #: __________________________ Group No.: __________________________
Subscriber Status: ☐ Full-Time ☐ Part-Time ☐ Self Employed ☐ Adult Military ☐ Student Full Time
☐ Student Part-Time ☐ Retired Date __________ ☐ Disabled ☐ Not Employed

Effective Date: __________________________

Authorization
I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Health System for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: __________________________ Date: __________________________
School-based Health Center

Parent/Guardian Approval for Administration of Over the Counter Medications

I approve the following list of over the counter medications to be given to my child by the School-based Health Center staff. You will be notified by telephone after your child is seen in the School-based Health Center.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificial tears</td>
<td>Wash out eyes, add moisture to eyes</td>
</tr>
<tr>
<td>Tylenol (Acetaminophen)</td>
<td>Pain, fever</td>
</tr>
<tr>
<td>Benadryl (Diphenhydramine)</td>
<td>Allergic reaction, allergies</td>
</tr>
<tr>
<td>Claritin (Loratadine)</td>
<td>Allergies</td>
</tr>
<tr>
<td>Cough syrup (Dextromethorphan)</td>
<td>Cough</td>
</tr>
<tr>
<td>Cough drops</td>
<td>Cough</td>
</tr>
<tr>
<td>1% Hydrocortisone Cream</td>
<td>Dry, itchy skin; allergic reaction</td>
</tr>
<tr>
<td>Motrin/Advil (ibuprofen)</td>
<td>Pain, fever</td>
</tr>
<tr>
<td>Maalox</td>
<td>Acid Reflux</td>
</tr>
<tr>
<td>Mucinex</td>
<td>Congestion</td>
</tr>
<tr>
<td>Neosporin</td>
<td>Cuts, scrapes</td>
</tr>
<tr>
<td>Saline Nose Drops</td>
<td>Runny, stuffy nose</td>
</tr>
<tr>
<td>Zantac (Ranitidine)</td>
<td>Acid reflux</td>
</tr>
<tr>
<td>Zyrtec (Cetirizine)</td>
<td>Allergies</td>
</tr>
</tbody>
</table>

My child is currently taking the following medications:

__________________________

Allergies:

__________________________

Printed Name of Parent/Guardian __________________________ Date ____________

Signature of Parent/Guardian __________________________ Date ____________
CONSENT FOR RELEASE OF EDUCATION RECORDS AND INFORMATION

I understand that the School District of Greenville County will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA), state statutes and regulations, and state and District policies and procedures to ensure confidentiality regarding the release of student information. No information will be released or secured without prior approval from the parent, except as provided by law.

The District has my permission to release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to representatives of the GHS School-Based Health program. I understand that the purpose of this consent is to refer my child for health-related services and treatment.

Consent to Release Confidential Information

By providing my signature below, I understand that granting consent for the release of personally-identifiable information from my child’s education records is voluntary and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

By providing my signature below, I understand the recipient of these records must obtain my written consent before it can further share my child’s information from the District with any other party, such as for the purpose of billing Medicaid. If I provide written consent for the service provider to share my child’s information with another party, the re-disclosure of my child’s information by the recipient may no longer be protected by the requirements of the FERPA.

The School District of Greenville County “School District” is independent of Greenville Health System “GHS” and is allowing GHS to provide treatment to students during the school day to those students who have authorized such treatment. I agree to hold the School District completely harmless for any injury, harm or loss that occurs during treatment by GHS or that arises out of treatment by GHS, unless such injury, harm, or loss occurs due to the negligence or willful misconduct of the School District or its directors, officers, employees, and agents.

Student’s Name ___________________________ Student’s Date of Birth ___________________________

Signature of Parent/Guardian/Surrogate Parent ___________________________ Date ___________________________
Short Form Consent to Participate in Research
You have given permission for your child to receive services through the School-based Health Center at your child's school. As part of our evaluation of the Center this school year, we are partnering with OnTrack Greenville to help research how well the Center helps students with doing well in school. OnTrack Greenville is an intensive effort to track how students progress at school and to coordinate efforts to correct their progress if they begin to veer off track. We are asking for permission to share limited information about your child's visit to the School-based Health Center with the researchers at OnTrack Greenville.

We would like to share: (1) that your child was seen; (2) the number of visits; (3) the number of times your child was sent back to class or sent home after a visit; and (4) if we made any referrals to outside resources for you and your family. We will NOT share any medical diagnoses or procedures related to your child's health.

The overall purpose of sharing this information with OnTrack is to track attendance and things that may or may not affect attendance. This information will be shared electronically by your child's power school number. Your child's name, your name, your address or your phone number will not be included. This information will only be shared one time this school year and it will be at the end of the school year.

The primary risk is potential loss of confidentiality. We have taken steps to minimize this risk by not including any readily identifiable information, by limiting access to this information to only those on the research/evaluation team, by keeping the information in locked files on password-protected computers, and only sharing the information through a secured process. Any final OnTrack Greenville reports and/or School-based Health Center reports will not include any identifiable information. All results will be shared as overall summaries.

There is no direct benefit to your child for participating in the study. However, the information shared helps us to continuously improve the services and care we provide. Participation is voluntary and does not affect your child's ability to be seen at the School-based Health Center. We will continue to treat your child if you agree or disagree to participate.

As mentioned above, this information will only be shared at the end of the school year. So, if between now and the end of the school year you change your mind about participating, just call us and let us know.

You may call us at 864-454-2341 to speak with Melinda Lavallee-Turner, Program Coordinator, or Dr. Kerry Sease, Principal Investigator, at any time if you have questions. If you agree to participate, we will send you a signed copy of this form.

Please sign your name below and print your child's name if you agree to participate.

Signature of Parent/Guardian __________________________       Date __________

Print Child's Name __________________________       Date __________