HEALTH RECORD

ST LAWRENCE SEMINARY MT CALVARY, WISCONSIN

ALL QUESTIONS ON THIS FORM MUST BE ANSWERED. ITEMS WITH A STAR (*) ARE OF ADDITIONAL IMPORTANCE.

This health examination form is to be completed and returned to St Lawrence Seminary. The family or personal physician of the student is in an ideal position to supply the significant history, physical findings and laboratory studies related to the student's health, and also to provide a critical evaluation of his health status.

EXHIBIT 50

TO BE COMPLETED BY PARENTS:

If parents are separated or divorced, which parent is to be notified in case of illness? ____________________

Do you wish the hospital or clinic to bill you directly or do you want the hospital or clinic to send the bill to your insurance company?

Hospital	☐ bill me directly	☒ send bill directly to insurance company
Clinic	☐ bill me directly	☒ send bill directly to insurance company

Please read the following, and if you are in agreement, sign in the appropriate spaces. There are three parts to this section, each covering a different point of health care. We need your signature (or an explanation of your non-signature) for all three sections.

(1) I give my permission for my son to receive health care by the seminary staff for illness or injury. I understand this care is overseen by the medical director through a Registered Nurse. This care includes administering first aid, medication, health screenings and transporting to medical appointments.

Signature of Parent or Guardian Fr. Donald J. McGuire S.J. (Guardian)

(2) In the event of an emergency, I give my permission to have my son treated as an outpatient or admitted to a hospital and to have surgery if necessary. I understand an attempt will always be made to notify me in case of an emergency.

Signature of Parent or Guardian Fr. Donald J. McGuire S.J. (Guardian)

(3) The undersigned parent/guardian of __________, in the event that he/she cannot be contacted through reasonable efforts, does hereby empower and grant to St Lawrence Seminary permission to consent to and authorize medical and hospital care and/or treatment for my above named child/ward. This authorization shall be valid for the period of time beginning August 19, 2000. I do hereby indemnity and hold harmless the physicians, hospital and other persons who act in reliance upon this authorization.

Today's date: 8/12/00

Witness:

Parent/Guardian Fr. Donald J. McGuire, S.J.

Parent/Guardian ____________________

FOND DU LAC REGIONAL CLINIC
100 South County Trunk W
Mt Calvary Wisconsin 53057

PATIENT REGISTRATION

Date 8/10/00

Please print the following information concerning your son/guardian, a student at St Lawrence Seminary, Mt Calvary WI.

PERSON RESPONSIBLE FOR PAYMENT (For a child, this is ordinarily the person who has custody) (GUARDIAN)

Last Name McGuire First DONALD Middle Initial J.

Mailing address P.O. Box 5250 Evanston, IL 60204
street address or P O Box number city state zip

Birth date 7/9/30 Social Security Number

Home Phone 847-864 4502 Work Phone Same

Check one: ☒ Single; ☐ Married; ☐ Separated; ☐ Widow; ☐ Divorced.

Relationship to seminary student: ☐ Parent; ☒ Legal Guardian ☐ Other (please state)

Employer MISSION FIDES Occupation ROMAN CATHOLIC PRIEST

Employer's address P.O BOX 5250 EVANSTON IL 60204
street address or P O Box number city state zip

INSURANCE INFORMATION Does the student have insurance? ☒ Yes; ☐ No.

Student's primary insurance:

Insurance Company BLUE CROSS - BLUE SHIELD OF ILLINOIS ID# Group#

Effective date Expiration date

Address where claim is to be sent
street address or P O Box number city state zip

Name of policy holder Relationship of student to policyholder Self

Medical assistance # Effective date Expiration date

What type of coverage? ☐ family coverage; ☒ single coverage.

(continued on other side)

SPOUSE'S NAME Last Name N/A First ____________ Middle Initial ______

Address and Phone (list only if different than the address of person responsible for payment, given on reverse side.)

Mailing address ____

street address or P O Box number *city* *state* *zip*

Phone (______) - (______)- (________)

Please give the following information for the spouse::

Social Security Number ____________ Occupation ____________

Employer ____________

Employer's Address ____________

Employer's Phone ____________

FOR EMERGENCY PURPOSES

Nearest relative or friend not at your address _

That person's relationship to student

Mailing address ___

street address or P O Box number *city* *state* *zip*

Phone

<u>AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:</u> I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services.

<u>ASSIGNMENTS OF BENEFITS:</u> I hereby authorize payment of benefits be made directly to Fond du Lac Regional Clinic for services provided to this patient by the Fond du Lac Regional Clinic. <u>I understand that I am financially responsible to Fond du Lac Regional Clinic for charges not covered by this assignment including those charges which my insurance carrier may consider above usual and customary.</u> I authorize refund of overpaid insurance benefits where my coverage are subject to coordination of benefits. In the event of default, I agree to pay all costs of charges including reasonable attorney's fees. I agree that if any of the information furnished on this form changes, it is my obligation to notify Fond du Lac Regional Clinic.

Fr. Donald J. McGuire, SJ. ____________ 8/10/00

Signature of responsible person *Date*