





Sponsor(s) Acknowledgement & Acceptance

Initials: \_\_\_\_\_ / \_\_\_\_\_

I/We understand that the SRA program includes four (4) phases and each student will complete the program at the pace that is unique to her needs. I/We also understand that each phase builds upon the internalization of the previous phase. I/We understand that the program's average length of stay is 14 – 18 months and I/We are committed to our daughter completing the SRA therapeutic program. This agreement renews automatically on a month-to-month basis. Terminating the Student's enrollment prior to the completion of the therapeutic program requires 30 days written notice.

I/We understand that the services offered by SRA are physically and emotionally challenging. Sponsor(s) give their consent for the Student to participate in all aspects and activities of SRA. Activities may include, but are not limited to: academic classes, academic counseling, therapy, experiential seminars, rigorous exercise, hiking, swimming, sporting games, activities off and on grounds, work projects, transportation, and intervention when deemed necessary. I/We also understand that these activities, as well as any other elements of SRA's programming, may involve a degree of risk to all participants.

Sponsor(s) knowingly assume the risk for the participation in the activities of SRA and release and discharge SRA, its agents, employees, and officers, from any and all claims, demands, actions, judgments, and executions which the Sponsor(s) may have against SRA for all personal injuries, and damage to property,, caused by or arising out of Sponsor(s) and/or Student's participation in the SRA program. I/We understand that SRA is fully licensed and insured, and agree that enrollment in Spring Ridge Academy and all activities relating thereto are governed by the laws of the State of Arizona and are under the jurisdiction of the courts of Arizona.

I/We understand and agree that the Student's personal effects and also her person may be searched at the discretion of the treatment staff for the purpose of revealing any prescribed or non-prescribed drugs or medications or any other substances or items that are not permitted. Body checks are performed at enrollment and if needed through enrollment. These are performed by a registered nurse or trained appointee, Students remain in their under garments during these checks. All prescribed medications that are to be taken by the applicant will be held in the possession of, and dispensed by SRA personnel. I/We understand and agree that should the Student runaway from the control and supervision of SRA staff during the term of the SRA program, SRA will use reasonable efforts to assist the Sponsor(s) in finding the Student and in obtaining her safe return. All appropriate law enforcement or security personnel of any federal, state, county, or municipal entity shall be directed to detail and retain custody of the Student until the Sponsor(s) or any SRA personnel are contacted, at which time SRA personnel may re-obtain custody or control of her.

Sponsor(s) hereby give consent and authorization for SRA personnel to physically restrain, control and detain the Student for the following purposes: to prevent the Student from jeopardizing her safety or the safety of others.

Sponsor(s) understands that Spring Ridge Academy is a family systems program and that we require at least one Sponsor to participate in the Parent Challenge and the Family Trainings all of which are key elements of the program.

SRA reserves the right to terminate the enrollment of any Student at anytime if there is a default in the performance of any of the terms of this Agreement by the Sponsor(s), or if in the sole discretion of SRA, Student is not a suitable resident of the school, or for any other reason SRA determines that the Student should not continue to reside at the school. This would include, but is not limited to, Sponsor(s) who are unwilling to follow the guidelines of SRA, or are, at the sole discretion of SRA, unreasonable or difficult to work with, and undermine student's focus at SRA by making plans with her for early withdrawal from the program prior to a mutually set discharge date with the program. In the event a Student's enrollment is involuntarily terminated, SRA shall arrange, at Sponsor(s)'s expense, to transport the Student back to Sponsor(s) address.

Sponsor(s) hereby acknowledge that they have read the entire Enrollment Agreement and that they understand and agree to its provisions. This agreement may be modified or amended if the amendment is made in writing and is signed by both parties.



Sponsor(s) Acknowledgement & Acceptance

Initials: \_\_\_\_\_ / \_\_\_\_\_

**Financial Terms and Agreement**

**REGULAR TUITION AND FEES:**

I/We the undersigned agree to pay Spring Ridge Academy upon admission for the following:

First Month's Tuition	\$8,800.00	Student Expense Deposit	\$250.00
Last Month's Tuition	\$8,800.00	Student Monthly Allowance	<u>\$100.00</u>
Enrollment Fee (Non-Refundable)	<u>\$2,500.00</u>		
Payable to "Spring Ridge Academy"	<u>\$20,100.00</u>	Payable to "SRA Student Fund"	<u>\$350.00</u>

Payment is made to *Spring Ridge Academy* in the amount of **\$20,100.00** and separate check to **SRA Student Fund** in the amount of **\$350.00**. The second month tuition will be prorated to reflect the unpaid days in the second calendar month. The monthly tuition fee covers the cost of room and board, academic classes, regularly scheduled seminars, and therapy as SRA determines. In the event that collection of any past due accounts is necessary, accrued costs of collection will be added to the account balance.

**Overdue Accounts will be handled in the following manner:**

15 days overdue accounts will be addressed by an email or phone call to collect payment  
 30 day overdue accounts will be prepared for discharge unless alternative payment methods have been created.

**ADDITIONAL COSTS TO REGULAR PROGRAM:**

**Student Expenses:**

A deposit of \$250.00 is charged upon admission for student expenses. This deposit will be used to pay for the following charges as they are incurred:

- Transportation: includes non-urgent or recurrent medical trips (\$25 per trip); special needs or activities other than regular program transportation (\$25 per trip); transportation to Phoenix or Flagstaff (\$120 per trip)
- Shuttle: transportation via shuttles to/from Phoenix Sky Harbor Airport
- Class Fees: The Sponsor(s) understand additional fees may be charged for supplies needed for elective classes (i.e. art, expressive movement, etc.)
- Allowance: \$100.00 for first month of enrollment and then \$75 per month thereafter to be deposited in your daughter's personal "checking" account. The monies will be used for clothing, hair styling, postage, school supplies, student outings and field trips. This "personal" checking account is part of the life skills taught at Spring Ridge Academy.
- Additional financial responsibilities may include costs to repair and/or replace property damaged by a student and/or for any costs incurred should a student require one on-one- supervision longer than 48 hours.
- The Student Expense Account must be maintained at \$250 during the student's stay at Spring Ridge Academy by monthly detailed billing in addition to the tuition billing and payable upon receipt to the SRA Student Fund. The unused portion will be reimbursed to parents up to 60 days after discharge.

**Medical/Pharmacy Expenses:**

The Sponsor(s) agrees to be financially responsible for all medical expenses by providing insurance information a credit card for medical providers to direct bill costs not covered by insurance. Sponsor(s) must complete the Medical Insurance and Credit Card Authorization form. Medical costs include: medical, dental, orthodontic, optical, urinalysis, lab work, psychiatric and psychological testing. If insurance and credit card information is not provided and payment is made by Spring Ridge Academy, a \$50 administrative fee will be charged per occurrence.

- 1) Sponsor(s) understands and agrees to be financially responsible for the monthly tuition of \$8,800.00. Sponsor(s) understands and agrees all monthly fees are payable in advance and due on the 1<sup>st</sup> day of each month.
- 2) Sponsor(s) understands and agrees that in the event the Student is taking prescription medication, the Student must have a medication review conducted by a psychiatrist. Sponsor(s) agrees to be financially responsible for the psychiatrist's review. Sponsor(s) agrees to be financially responsible for the cost of any medication purchased for the Student. All medication will be ordered through a local pharmacy. SRA agrees not to purchase, administer, or authorize any medication for the Student without prior consent of the Sponsor, unless in the case of an emergency and SRA is unable to contact the Sponsor(s).



Sponsor(s) Acknowledgement & Acceptance

Initials: \_\_\_\_\_ / \_\_\_\_\_

- 3) Sponsor(s) agrees to be financially responsible for the cost of repairing or replacing any property lost, stolen, damaged, defaced, or destroyed by the Student.
- 4) Sponsor(s) agrees to be financially responsible for the costs in the event the student leaves SRA without authorization. An accounting of the expenses incurred by SRA while assisting the Sponsor(s) in finding and returning the Student will be made to the Sponsor(s).
- 5) Sponsor(s) agrees to pay the costs for collection of any amounts due under this agreement, including reasonable attorneys' fees, whether or not legal action is commenced, and in addition to pay interest (1½ percent per month) on all sums not paid within thirty (30) days after the due date.
- 6) Sponsor(s) understands SRA takes no responsibility for the approval or processing of insurance reimbursements, payments, or billings.
- 7) Sponsor(s) understands terminating the Student's enrollment at Spring Ridge Academy prior to the completion of the four phases requires a written notice thirty days prior to the date of termination. If the Student leaves without a thirty day written notification, the parents will be billed for thirty days tuition. If Spring Ridge Academy requests that Student leave, a tuition refund will be prorated from the date of departure. A \$50 packing fee will be charged for all personal belongings to be shipped.
- 8) Sponsor(s) understand that upon discharge, if the \$250 expense deposit is insufficient to pay current and estimated personal expenses, a portion of any tuition overpayment will be transferred and credited to your student fund account, and if there is a balance due for tuition, any Student Fund overpayment will be transferred and credited to your tuition account.
- 9) Sponsor(s) hereby acknowledge that I/we have read the entire Financial Agreement and that I/we understand and agree to its provisions. This agreement may be modified or amended if the amendment is made in writing and is signed by both parties.

**Medical Insurance Agreement**

I/We agree to provide current medical insurance during the entire enrollment of above named Student at Spring Ridge Academy. I/We understand that I/we are responsible for all medical, dental, and psychological expenses for this student, notwithstanding any health insurance I/we may have. I/we also understand and agree that **Spring Ridge Academy cannot guarantee that all healthcare providers will honor all insurance coverage. Consequently, I/we may have to file direct claims with my/our insurance carrier.** As a means to assist parents in recovering costs from insurance companies, upon request, Spring Ridge will provide parents with a quarterly insurance billing statement for their use in filing for possible reimbursement. However, we do not provide the services of verification of benefits, pre-authorization, claim submission and tracking, appeals or review. For assistance with navigating the health insurance bureaucracy, parents may seek advice with companies that specialize in health insurance claims management and advocacy.

**Permission to Photograph**

I/We the undersigned give permission and understand that Spring Ridge Academy staff will be taking an identification photograph for their files. \_\_\_\_\_ Yes      \_\_\_\_\_ No

I/We agree to have our student photographed and to have the photograph placed in a Spring Ridge Academy brochure and/or on the web page. \_\_\_\_\_ Yes      \_\_\_\_\_ No

I/We agree to have our student photographed and to have the photograph placed in the Spring Ridge Academy password restricted Parent Page \_\_\_\_\_ Yes      \_\_\_\_\_ No

**Lost Items Release**

Spring Ridge Academy recommends that expensive or sentimental items should not be brought to the program. Spring Ridge Academy makes every effort to protect and ensure the safekeeping of all the Student's personal belongings. I/We, the undersigned, understand and agree that Spring Ridge Academy shall not be responsible or liable for loss, damage, neglect, misplacement, or theft of the Student's property even if left behind on visits, leaves, or when the Student exits the Program.





13690 S. Burton Rd. – Spring Valley, AZ 86333

Office: (928) 632-4602 – Fax: (928) 632-7661

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

(Reproduce this form as needed)

Spring Ridge Academy (SRA) is authorized to use/disclose information as noted below about:

STUDENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

To/From the following person/organization:

NAME \_\_\_\_\_ TITLE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

- \_\_\_\_\_ Admission and discharge summaries
- \_\_\_\_\_ Psychological and/or Psychiatric evaluation(s), reports, testing, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations
- \_\_\_\_\_ Treatment, aftercare plans and other similar plans
- \_\_\_\_\_ Social, family, education, and vocational histories
- \_\_\_\_\_ Verbal progress reports, observations and recommendations
- \_\_\_\_\_ Information about how patient's condition(s) affects or has affected student's ability to participate in school and to complete tasks or activities of daily living
- \_\_\_\_\_ Academic & educational records, including achievement & other tests' results, reports of teachers' observations, and all other school or special education documents
- \_\_\_\_\_ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: \_\_\_\_\_ Do not release these
- \_\_\_\_\_ Other \_\_\_\_\_

Dates of care included: From \_\_\_\_\_ to \_\_\_\_\_ and From \_\_\_\_\_ to \_\_\_\_\_

The information will be used/disclosed for the following purposes: \_\_\_\_\_

- I understand and agree that this Authorization will be valid and in effect until: \_\_\_\_\_ I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
- I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Spring Ridge Academy.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that this professional will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signatures: \_\_\_\_\_ Parent/Guardian Signature Date \_\_\_\_\_ Parent/Guardian Signature Date

I, an authorized representative from SRA, have discussed the issues above with the client and/or student's personal representative. My observations of student's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_ Signature & Printed Name of Authorized SRA Representative \_\_\_\_\_ Date



**AUTHORIZATION FOR TREATMENT  
CONSENT FOR COMMUNICABLE DISEASE TESTING, HIV AND STD TESTING**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT**

I/We, the custodial Parent(s) and/or legal Guardian(s) of the above named minor, hereby authorize Spring Ridge Academy, through health care professionals, to render the necessary health care to the above named minor.

I/We authorize and consent to any X-ray examination, anesthetic, inoculation, vaccination, medical or surgical diagnosis or treatment and hospital care to be rendered to the above named minor under the general or special supervision and upon the advice of a licensed physician. I/We hereby consent to X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a licensed dentist. I/We hereby authorize and consent for any psychological assessment, treatment, hospitalization and psychological testing from a licensed professional counselor, psychologist, and psychiatrist to be rendered to the above named minor.

I/We hereby give consent and authorize SRA to administer to the Student a routine urinalysis or blood test for drugs on admission and randomly as indicated by treatment needs.

In my/our absence or in the event that I/we cannot be contacted, I/we hereby designate, empower, and authorize Spring Ridge Academy to act in my/our stead authorizing any specific procedures and/or assisting in making elective decisions relating to the above named minor's care. I/We are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees can be made as to the result of treatment or examinations taking place. It is the intent of this instrument to authorize, consent to and empower health care professionals selected by Spring Ridge Academy to give the care they deem necessary to my/our child, in my/our absence, or when I/we cannot be contacted, or in an emergency situation when immediate care is deemed to be in the best interest of the child by the health care professional's best judgment.

**CONSENT FOR COMMUNICABLE DISEASE TESTING - HIV AND STD TESTING:**

I/We further give consent for communicable disease testing, including but not limited to, HIV, Hepatitis and sexually transmitted diseases testing.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Parent/Guardian







## OVER-THE-COUNTER (OTC) / AS NEEDED (PRN) - MEDICATION APPROVAL LIST

**STUDENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**I agree to the check-marked and listed OTC medications noted below, to be used by my daughter under the supervision of staff (as regulated by school nurse) on an as needed basis.**

**Parent/Guardian Printed Name:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

### Pain relievers / Stomach Discomfort

Extra Strength Tylenol (acetaminophen) 500mg 1-2 tabs by mouth every 6 hours as needed for pain or fever
Motrin/Advil (ibuprofen) 200mg 1-2 tabs by mouth every 4-6 hours as needed for pain or fever
Excedrin Migraine (acetaminophen/aspirin/caffeine) 2 caps by mouth once daily as needed for migraine headache (DO NOT GIVE AFTER 4PM)
Topical pain rub (Icy Hot/Ben Gay/Mineral Ice) apply to affected area every 4 hours as needed for muscle pain
Orajel or generic equivalent as needed for tooth/mouth pain—use per manufacturer instructions
TUMS/ROLAIDS antacid tablets (calcium carbonate) 1-2 chewable tabs by mouth as needed for indigestion/heartburn
Pepto Bismol (bismuth subsalicylate) 30ml by mouth every ½ hour to 1 hour, not to exceed 8 doses in 24 hours as needed for diarrhea/heartburn/indigestion
Simethicone (anti-gas) 125mg 1-2 tabs by mouth as needed for gas discomfort-up to 4 tabs per day
Colace (docusate sodium) 100mg 1-3 capsules by mouth daily as needed for constipation
Milk of Magnesia 15ml by mouth daily as needed for constipation

### Cold/Flu / Sinus / Allergy Relief / Miscellaneous

Benedryl (diphenhydramine) 25mg capsules 1-2 by mouth every 4 hours as needed for rash or hives. <b>Do not give for seasonal allergies</b>
Cough suppressant/expectorant tabs (guaifenesin 400mg+dextromethorphan 20mg) 1 tablet every 4 hours as needed for cough/congestion-up to 4 in 24 hours
Sore throat lozenge 1 by mouth every 4 hours as needed for sore throat pain
Suphedrine PE 10mg tabs (phenylephrine hydrochloride) 1 tab every 4 hours as needed for sinus congestion (max 6 tabs in 24 hours)
Claritin (loratadine) 10mg tab 1 by mouth daily as needed for allergy symptoms
Cough drop (Halls or generic equivalent) 1 by mouth every 4 hours as needed for cough/congestion
EmergenC take 1 packet in water every 4 hours as needed for sickness or immunostimulation
Coldeez lozenges for relief of cold symptoms
Antifungal spray or cream—use topically per manufacturer instruction for relief of symptoms related to athletes foot or other fungal infections
Tussin 10 ml every 4 hours as needed for cough
Triple antibiotic cream/ointment—use topically per manufacturer instructions as needed for minor cuts/scrapes/burns/bites
Benadryl gel or cream—use topically per manufacturer instructions for minor skin rashes
Hydrocortisone 1% cream—use topically per manufacturer instructions as needed for itching
Monistat 7 (miconazole suppository+cream)—use as directed as needed for yeast infection
Melatonin 3mg take 1 at bedtime as needed for insomnia
Multivitamin-use per manufacturer recommendations as needed for dietary supplementation



**Credit Card Agreement – Health Care Expenses**

**Please attach a legible/enlarged copy of your credit card. Front and back of the card are required.**

I/We, the parents/guardians of \_\_\_\_\_ agree to provide credit card  
(Student’s Name)  
information during the entire enrollment of above named Student at Spring Ridge Academy. I/We understand that I/we are responsible for all medical, dental, and psychological expenses notwithstanding any health insurance I/we may have. I/we authorize the health providers, including pharmacies, used by Spring Ridge Academy to charge my/our Visa/MasterCard (copy enclosed) for health services and prescriptions provided to the above named student. It is understood that Spring Ridge Academy cannot guarantee that all healthcare providers will honor all insurance coverage. Consequently you may have to file direct claims with your insurance company.

Credit Card Authorization:

I, \_\_\_\_\_, authorize the health providers of Spring Ridge Academy to charge my/our  
(Name of Card Holder)

\_\_\_\_ Visa \_\_\_\_ MC - Acct. Number \_\_\_\_\_ Exp Date \_\_\_\_\_ Sec Code \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_  
Signature of Cardholder

\_\_\_\_\_  
Date

**Medical Insurance Information**

**Please attach a legible/enlarged copy of your insurance ID card. Front and back of the card is required.**

**Primary Insurance Company:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Benefits Phone: \_\_\_\_\_ Bin #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_ Policy Holder’s Date of Birth: \_\_\_\_\_

Policy Holder’s Employer: \_\_\_\_\_

Policy Holder’s Phone #: \_\_\_\_\_ Policy Holder’s SSN #: \_\_\_\_\_

Policy Holder’s Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip



**AUTHORIZATION TO RELEASE ACADEMIC RECORDS**

*(Reproduce this form as needed)*

STUDENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DATES ATTENDED: \_\_\_\_\_

I/We hereby grant the school listed above to release Academic transcripts to Spring Ridge Academy for the above named Student. Permission is granted to release the following school records to Spring Ridge Academy:

- Official Transcript of Credit
- Withdrawal Grades
- Including Incomplete Classes
- Test Data
- Health Records
- Counseling
- Consultants
- Referral Therapists
- Other \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

Expiration Date: Two years from Enrollment Date

Send transcripts to:  
Spring Ridge Academy  
13690 South Burton Road  
Spring Valley, AZ 86333  
Fax (928) 632-7661  
Questions (928) 632-4602 x1040

## Chapel Rock Participant Information and Permission Form

DISCLOSURE: CHAPEL ROCK programs involve a variety of activities that often include warm-ups, games, group initiative problems, high and low ropes course elements, rock climbing, rappelling, kayaking, orienteering, and other rigorous physical adventure activities. **(The level of participation in a program activity is at all times completely up to the individual.)** Trained professional staff conducts all programs; yet there is a risk which must be assumed by each participant that he/she may suffer an emotional or physical injury, disability or death. Every participant in CHAPEL ROCK programs is encouraged to have health/accident insurance coverage. In addition, certain health/medical information must be made known to the instructor(s) conducting programs, so that they are prepared to respond appropriately if the need arises. This information will be held in confidence. Please complete this form and return it to CHAPEL ROCK prior to participating in any activities.

### PARTICIPANT INFORMATION:

1. Name \_\_\_\_\_ Date of Participation: \_\_\_\_\_
2. Do you have any limiting physical or mental disabilities or medical restrictions (temporary or permanent) that could present a hazard to yourself or others during the duration of this program?
  - a. \_\_\_ Yes \_\_\_ No If yes, identify and explain:
3. Do you have any allergies, reactions to medications, any other medical limitations? \_\_\_ Yes \_\_\_ No  
If yes, identify and explain:
4. Have there been any recent major life changes? (E.g., Job changes, death in family, etc)

**RELEASE OF LIABILITY:** I understand that parts of the CHAPEL ROCK program may be physically or emotionally demanding. I affirm that my health is good, and that I am not under a physician's care for any undisclosed condition that bears upon my fitness to participate in CHAPEL ROCK activities. I understand that each participant must assume the risk of physical injury that could result from any of these activities. I release CHAPEL ROCK, and its staff members, from all liability for any injury to me from participation in CHAPEL ROCK activities. I understand that these terms shall serve as a release of liability for my heirs, executors, and administrators and for all members of my family. I have carefully read this Disclosure and Release of Liability and fully understand its content.

Date \_\_\_\_\_ Signature \_\_\_\_\_

**PHOTO/MEDIA RELEASE:** I grant to CHAPEL ROCK, and persons acting for or through them, the rights to use, reproduce, assign, and/or distribute photographs, films, videotapes, and sound recordings of myself for use in materials they may create.

Date \_\_\_\_\_ Signature \_\_\_\_\_

**PARENTAL WAIVER OF CLAIMS:** Parental permission must be secured for participants who are not of legal age (18 years). If you are not yet classified as a legal adult, your parent(s) or legal guardian(s) must complete the following:

I/we \_\_\_\_\_ (parents' or guardians' name(s)) give permission for my (our) child \_\_\_\_\_ (child's name) to participate in the CHAPEL ROCK program and associated field trip(s). Should my/our child become injured, I/we request that the trip leader or designated Chapel Rock staff secure emergency medical services to aid my/our child, if in their judgment such services are necessary. I/we agree to incur any additional expenses associated with such action. As parents/guardians, I/we have decided (with or without medical advice) that my/our child is physically, mentally, and socially able to participate, and I/we acknowledge that any medical or accident insurance we consider necessary will be my/our responsibility to locate and purchase. Furthermore, I/we have read all sections of this form and do hereby release CHAPEL ROCK and its employees from liability for any damages, injuries, or losses which may occur while said child is participating in this CHAPEL ROCK program.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature (if participant is under age 18)