



SUWS of the Carolinas/Seasons


“GETTING STARTED”



<input type="checkbox"/> MATERIALS REVIEW	<p>If you haven't already done so, review these materials. An admissions counselor is available 24/7 to answer any questions you might have.</p>
<input type="checkbox"/> PAPERWORK <u>NOTE:</u> The State of North Carolina requires receipt of completed enrollment documents before SUWS of the Carolinas can take custody of your child	<ul style="list-style-type: none"> • The paperwork has two (2) parts: The Application (completed online) and the Enrollment Agreement. (<i>this document</i>.) <ol style="list-style-type: none"> (1) The Application: (2) The Enrollment Agreement (<i>this document</i>), <i>pages 1-29</i> can be downloaded * <i>We will need a copy of the court agreement that outlines Custody of your child if you are divorced. In the case of Joint Custody, we will need both parents to sign the enrollment agreement documents.</i>
<input type="checkbox"/> CLINICAL APPROVAL	<p>This process can be accomplished within 24 hours.</p> <ul style="list-style-type: none"> • Once we receive your application, we submit it to our clinical staff for review and approval. • We will notify you via phone or e-mail once the review process has been completed. • At this time students are assigned to groups based on gender, age, specific clinical needs and therapist expertise.
<input type="checkbox"/> Pre-SUWS of the Carolinas Travel Arrangements	<p>As soon as you know <i>approximately</i> when your child will be attending SUWS of the Carolinas, you can start working on travel arrangements. Please keep the following in mind:</p> <ol style="list-style-type: none"> (1) Purchase airline tickets ONLY AFTER your child has been accepted into the program. When possible purchase one way tickets. (2) Schedule your child's arrival into Asheville, North Carolina between the hours of 10:00 a.m. and 3:30 p.m. if we are meeting your child at the airport. If you are going to be driving your child to base please schedule for a weekday between the hours of 9:00 am and 4:30 pm. (3) If you send your child unaccompanied, please make flight arrangements for the Asheville Regional Airport and include a picture of your child as it helps us identify him or her at the gate, and (4) <u>If sending your child unaccompanied is not an option for your family, the admissions department can help you arrange travel plans for your child.</u>

WHAT TO BRING

Now that your child has been accepted and the transportation arrangement have been made, what do you need to pack?

<input type="checkbox"/> CLOTHING	<p>SUWS of the Carolinas provides all clothing and gear to help ensure optimal safety in all weather conditions.</p> <p>All you <u>need</u> to pack is 10 pair of underwear, and 3 sports bras for the young ladies.</p>
<input type="checkbox"/> EYEWEAR	<p>If your child requires corrected vision, please send glasses only. It is Non hygienic to wear contact lenses in the field.</p>
<input type="checkbox"/> MEDICATIONS 	<p>(1) Section 16 of the application is critical. Make sure that you COMPLETELY fill out the medications section including the exact name of the medication as it appears on the packaging, dosage, form, and administration time(s). DO NOT send anything with your child unless you include it in this section.</p> <p>(2) Send a 30-day supply of each of your child's medications. If your child arrives with less than a 30-day supply, please have your physician write the necessary prescription. Your credit card will be charged for the initial physical, medication(s), and any other medical expenses. If you are in mid-cycle and your insurance won't cover a refill at this time, make arrangements with the admissions counselor to get a refill to the program before his/her supply is exhausted.</p> <p>(3) Before the 30-day supply is exhausted, please send additional medication to Base Camp:</p> <p style="text-align: center;">363 Graphite Road Old Fort, NC 28762</p> <p>(4) IF your child requires an inhaler, you must send two (2) inhalers. (If your child requires more than one kind of inhaler, send two (2) of each.)</p> <p>(5) IF your child requires epinephrine shots for allergic reactions, you must send two (2) Epi-pens.</p>
MISCELLANEOUS	<p>Please leave expensive items, such as jewelry and cell phones, at home.</p>
<input type="checkbox"/> ORTHODONTURE APPARATUS	<p>IF your child requires an orthodonture apparatus, such as a retainer, please include a container in which to keep it when not in use.</p>
<input type="checkbox"/> PHOTO	<p>This is especially helpful for identification purposes if your child is traveling unaccompanied.</p>
<input type="checkbox"/> SUNGLASSES	<p>Sunglasses are NOT allowed. Exceptions will only be made for specific medical conditions.</p>

WHAT'S NEXT

What will happen during the first week?

PHONE CALLS

- You will receive a phone call notifying you of your child's safe arrival.
- You will receive a phone call to schedule your first call with your child's field supervisor/therapist the first business day after your child's arrival.
- You and the field supervisor/therapist will schedule follow up calls at regular intervals throughout your child's SUWS experience.

EXTRANET (WEBSITE)

- You'll receive an e-mail directing you to your child's website within **three business days AFTER** your child has arrived in the program.
- A new photo will be uploaded to the site each week for your viewing enjoyment.
- Every effort will be made to update the progress report on a weekly basis. The Extranet is intended to support the communication received from the therapist, NOT replace it. We would love to upload more photos, but there just isn't time and manpower. Therapy—not photography—is our main focus! You can also refer to this site to learn more about our staff, facility, and post SUWS of the Carolinas travel arrangements.

E-MAIL

Your child's therapist is available to you via e-mail, but please remember that his or her responses won't be instantaneous as the main focus is working with your child in the field.

LETTER(S)

- Your child will receive **journaling and writing assignments** as part of his or her therapeutic experience.
- You will be asked to write and fax or e-mail letter(s) to your child. Friends and family are discouraged from sending cards/letters. Your Therapist can address this and direct the frequency of correspondence.
- The letters written by your child throughout the program are typically sent or given to you with other documentation **at the end of the program.**



THE FUTURE

As your child nears program completion, you have been working with the field supervisor/therapist and other helpful people to determine the next step. What needs to happen to make that transition a smooth one?

PARENT WORKSHOP (MID WAY INTO PROGRAM)

- Parents are encouraged to attend this engaging two-day, activity-based workshop led by Dr. Brooke Judkins, the Family Program Coordinator at SUWS of the Carolinas.
- Designed to complement the Trail's End experience, it provides educational and community support for parents during their child's stay at SUWS of the Carolinas.
 - Workshops take place at the Wolf Creek Lodge and recommendations for area lodging will be provided.
 - It is recommended that parents attend a workshop when their child is mid-way through the program (around weeks 3, 4, or 5).

POST-SUWS TRAVEL ARRANGEMENTS

Remember the **Seasons program ends on a Tuesday** and the **SUWS Adolescent program ends on a Wednesday!** As mentioned previously, it is essential to identify the aftercare option *at least a week prior to your child's departure* from the program to allow time for transition into the on-call search and rescue phase. As such, the decision about aftercare placement should be made no later than the Tuesday prior to your child's graduation.

- (1) **Flights:** Schedule a departure flight from Asheville **NO EARLIER than 2:00 p.m. EST**, as graduation, travel time to the airport, and new airport regulations and procedures prohibit departure from Asheville before that

time.

- (2) **Gear:** You have purchased all the gear that your child has been using to participate in the program. If **we** will be taking your child to the airport, **we** will bag the gear for easy check-in at the airport. If **you** are going to be taking your child from the program, a bag will be provided for **your** convenience.
- (3) **Medications:** Medications **cannot** travel with your child if he or she is going on to a placement unescorted. **You will need to make arrangements with the placement to have medications there to meet your child after SUWS of the Carolinas.** SUWS of the Carolinas will ship all “excess” medications home.

❑ **Adolescents**
Parent Meeting/
Trail’s End



In your communications with the field supervisor/therapist, you will discuss specific Parent Meeting/Trail’s End arrangements for your family. Based upon the therapeutic needs of your child, you and your field supervisor/therapist will determine if it is appropriate for you to attend. Parent meeting will be an opportunity to ask questions, share concerns, reduce anxieties concerning trail’s end, etc.

- (1) When planning transportation from the airport to Old Fort, note there is no public transportation. (*Refer back to the Extranet for helpful driving directions and rental car information.*)
- (2) Parents attending Parent Meeting/Trail’s End need to make lodging reservations for **Sunday and Monday evening prior to the Wednesday graduation.** (*Refer back to the Extranet for possible hotel accommodations.*)
- (3) Parents will typically meet at **9:00 am** for the parent meeting **at the Wolf Creek Campus**
- (4) During the Parent Meeting on **Monday**, your field supervisor/therapist will provide information about **where and when to meet** for Trail’s End on **Tuesday** morning.
- (5) **Graduation Ceremony** takes place early on **Wednesday** morning

❑ **Seasons**
Parent Meeting/
Trail’s End



In your communications with the field supervisor/therapist, you will discuss specific Parent Meeting/Trail’s End arrangements for your family. Based upon the therapeutic needs of your child, you and your field supervisor/therapist will determine if it is appropriate for you to attend. Parent meeting will be an opportunity to ask questions, share concerns, reduce anxieties concerning trail’s end, etc.

- (1) When planning transportation from the airport to Old Fort, note there is no public transportation. (*Refer back to the Extranet for helpful driving directions and rental car information.*)
- (2) Parents attending Parent Meeting/Trail’s End need to make lodging reservations for **Sunday evening prior to the Tuesday graduation.** (*Refer back to the Extranet for possible hotel accommodations.*)
- (3) Parents will typically meet at **9:00 am** for the parent meeting **at the SUWS of the Carolinas Base Camp**
- (4) During the Parent Meeting on **Monday**, your field supervisor/therapist will provide information about **where and when to meet** for Trail’s End that occurs **later on that day.**
- (5) **Graduation Ceremony** takes place early on **Tuesday** morning.



In addition to the SUWS of the Carolinas application, we **require** the following information along with the remainder of this paperwork and the **Enrollment Agreement 24 hours prior to admission:**

1. Copy of a current Immunization record.
2. Copy of the front and back of your medical insurance card.
3. A current photograph of your child.
4. Copy of Custody Agreement if parents are divorced.
5. Statement of the most recent dental examination invoice, insurance statement, or handwritten note from dentist's office are all fine.

Please fax all information to **704-496-2265**
or emailed to admissions@suwscarolinas.com

We will not be able to outfit your child until all Supplemental Paperwork is in and Payment has been decided.

Any questions pertaining to these requirements or the remainder of the application can be directed to your Admissions Counselor at 888-828-9770.

Thank You

SUWS OF THE CAROLINAS PROGRAM ENROLLMENT AGREEMENT

This agreement ("Agreement") is entered into by and between SUWS OF THE CAROLINAS, a Delaware limited liability company (hereinafter "SUWS "), operating SUWS OF THE CAROLINAS, a licensed program which is described in the program materials that Sponsor has received previously and which is made a part of this Agreement by reference (the "Program") and _____ parent(s) and /or guardian(s) of the Student (hereinafter the "Sponsors").

Sponsor's address is : _____ and phone is: _____ . In consideration of the mutual promises set forth in this Agreement, SUWS , and Sponsor (hereinafter the "Parties") mutually agree as follows:

1. SPONSOR'S REPRESENTATIONS. Sponsor warrants that Sponsor is the legal parent(s) and/or guardian(s), having legal custody, of the following child: _____ (full and preferred name), whose birth date is _____ (hereinafter the "Student"), and that Sponsor desires to and does hereby contract with SUWS for the Student's enrollment in the Program according to the terms and conditions of this Agreement. In entering into and performing under this Agreement, SUWS is relying on all representations and promises of the Sponsor contained or expressed in this Agreement and all other documents and information sheets from Sponsor to SUWS , and Sponsor expressly warrants the truth and accuracy of the same.

2. ENROLLMENT OF THE STUDENT. Upon Sponsor's initial payment as set forth in Exhibit "A," and completion of this Agreement, the Enrollment Application and all related documentation, and upon SUWS' execution of this Agreement, SUWS shall accept the Student conditionally for enrollment in the Program, subject to the terms and conditions of this Agreement. Sponsor acknowledges and agrees that SUWS' conditional acceptance of the Student is subject to the personal evaluation and screening process conducted by SUWS prior to completion of the Assessment phase of the Program. If the Student satisfies SUWS' screening criteria, SUWS shall accept the Student and, except as otherwise provided herein, permit the Student to complete the Program. If the Student fails to satisfy SUWS' screening criteria, the Student will be returned promptly to Sponsor and a deduction for all reasonable expenses incurred by SUWS on behalf of the Student and/or the Sponsor prior to the Student's return.

3. TERM OF AGREEMENT/CUSTODY. Assuming the Student is accepted into the Program, the term of this Agreement shall be a minimum of **28 Days** beginning with the Student's arrival in, now anticipated on _____ (the "Arrival Date"). On the Arrival Date, Sponsor shall transfer, by a Power of Attorney in the form received and executed by Sponsor, temporary custody of the Student to SUWS for the duration of the Agreement, unless either party terminates this Agreement prior thereto by giving written notice to the other party pursuant to the terms of this Agreement or until the Student attains the age of nineteen (19), unless the Student (a) has otherwise been placed in the custody of SUWS by a court of proper jurisdiction or (b) voluntarily consents in writing to remain in the Program for any period of time beyond said nineteenth (19th) birthday.

4. PROGRAM COSTS AND PAYMENT TERMS.

A. PROGRAM FEE. The Student is accepted with the expectation that the Student will complete the entire Program. Unless otherwise set forth in Exhibit "A," the Program fee is **\$465.00/day** with an initial enrollment fee of **\$2000.00**.

B. SCHEDULE AND METHOD OF PAYMENT OF PROGRAM FEES; LATE FEES; EXTENSIONS.

(1) At the time of admission, private pay sponsors shall pay the full initial amount of the student's scheduled stay plus the enrollment fee.

(2) This initial payment may be paid by check. All subsequent payments, if any, shall be paid only by accepted credit card (VISA, Mastercard or American Express), wire transfer or pre-authorized electronic check debit (ACH).

(3) Sponsor shall also provide a valid credit card number with available credit at the time of admission. In the event that any fees, costs or subsequent extensions, including but not limited to the initial physical cost, medication costs, outfitting costs and additional medical expenses, are not paid when due, Sponsor authorizes the program to charge these items, including late fees, to this credit card number.

(4) With the exception of the discharge summary, student files and records will not be released after a student discharges until all tuition and fees are paid in full.

(5) Students with student loans must provide a copy of an executed promissory note from the lending institution at the time of admission. Actual funding must take place within five days of enrollment. Students receiving school district assistance must pay tuition and fees when due. The program will refund Sponsor upon receipt of payment from the school district.

(6) Any extension must be agreed upon by staff and sponsor prior to its commencement. Payment for an extension must be paid in advance for the full length of the additional stay. Failure to pay within the first week of the extended period could result in immediate student discharge.

C. EMERGENCY ADMISSION EXCEPTION. Upon written approval by the program, the Sponsor of a student who is admitted within 48 hours of the initial call shall pay a deposit of a minimum of 10 days and sign an enrollment agreement. This deposit must be secured by a third party, such as a credit card, wire transfer, ACH transfer, or cashier's check. Personal checks are not acceptable for deposits. Full payment for the program's minimum length of stay must be received no later than seven days of admission. If payment for the remainder of the agreed upon minimum length of stay has not been received within seven days of admission, the student will be discharged prior to 10 days.

D. PAYMENT/CANCELLATION REFUNDS. A cancellation received less than seven (7) days prior to the arrival date will result in a 50% refund. The amount retained by SUWS may, if deemed appropriate by SUWS , be used as credit against any future enrollment of the Student.

E. **EARLY WITHDRAWAL OF STUDENT.** If Sponsor withdraws Student before expiration of the minimum period of enrollment without the recommendations of the Program Director, Sponsor forfeits the remaining balance of the minimum stay. Any pre-payments above and beyond the minimum stay will be reimbursed to Sponsor.

F. **ADDITIONAL COSTS AND EXPENSES.** In addition to the Program fee, Sponsor agrees to pay for the following expenses of the Student: transportation from the Student's current residence to Program, and return transportation to the Student's current residence; food and lodging expenses for any holding period before commencement of the Program and/or after completion of the Program; all medical, dental, hospital, and related expenses incurred by or for the Student and all required personal items specified in the student clothing list. Sponsors are also responsible for any additional escort fees required for transporting Student to and/or from the Program to another location (i.e. airport, doctor's appointment, or special event). Sponsors are responsible for the cost of any psychiatric evaluations performed by a psychiatrist

G. **PERSONAL INJURY AND DAMAGE TO PROPERTY.** Sponsor agrees to accept full responsibility for (1) the repair or replacement of any property damaged, defaced, or destroyed by the Student, whether owned, leased, or controlled by SUWS or any third party, and (2) any personal injury to any SUWS personnel, other students or third parties caused, in whole or in part, by the Student; and to promptly reimburse SUWS for any costs and expenses, including legal fees, it may incur in connection therewith

H. **RUNAWAY EXPENSES.** In the event the Student runs away from the Program, SUWS will make every reasonable effort to find the Student and return the Student to the Program or to the Sponsor. An accounting of the expenses incurred by SUWS in finding and returning the Student will be made to the Sponsor who agrees to accept full responsibility for any and all such costs and expenses, and to pay the same within seven (7) days of the Sponsor's receipt of said accounting.

I. **LOSS OR DAMAGE TO STUDENT'S PROPERTY.** SUWS is not liable for any loss of or damage to any of the Student's property. The Student is fully responsible for the same at all times.

J. **SUBCONTRACTING.** Sponsor agrees and consents to SUWS' subcontracting certain services to be rendered under this Agreement to persons or entities deemed by SUWS to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. SUWS is not responsible for the services provided by such third-party contractors and is hereby released from any liability arising from such services. All clinicians furnishing services to the Student, including any psychiatrists, psychologists, mental health professionals, or internists or the like, are independent contractors with the client and are not employees of SUWS. The Student is under the care and supervision of his/her attending clinician and it is the responsibility of the Student's clinician to obtain the Sponsor's informed consent, when required, for medical, surgical, or psychiatric treatment, special diagnostic or therapeutic procedures, or other services rendered the Student under the general and special instructions of the clinician.

K. **NURSING CARE.** SUWS provides only general nursing care unless, upon orders of the Student's physician, the Student is provided more intensive nursing care. If the Student's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the Sponsors. SUWS shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that Student is not provided with such additional care.

5. ASSUMPTION OF RISKS; RELEASES AND INDEMNITIES. Sponsor acknowledges serious hazards and dangers, known and unknown, inherent in the Program, including but not limited to ranch, agricultural and vocational activities, emotional and physical injuries, illness or death that may arise from strenuous hiking, climbing and camping in a natural environment, exposure to the elements, plants and animals, running away from the Program, "acts of God" (nature), the ropes course, kayaking, water sports, stress, involvement with other students, self-inflicted injuries, and transportation to and from the Program's field location(s). Sponsor understands that in participating in the Programs Student will be in locations and using facilities where many hazards exist and is aware of and appreciates the risks, which may result. Sponsor understands that accidents occur during such activities due to the negligence of others, which may result in death or serious injury. Sponsor and Student are voluntarily participating in the Programs with knowledge of the dangers involved and agree to accept all risks.

In consideration for being permitted to participate in the Programs, Sponsor agrees to not sue, to assume all risks and to release, hold harmless and indemnify SUWS and any and all of its predecessors, successors, officers, directors, trustees, insurers, employees, managers, agents, volunteers, community organizations, administrators, heirs, attorneys, executors, assigns and/or related or affiliated business entities including, but not limited to, Aspen Education Group, Inc. 5 and Aspen Health Services Corporation (collectively all of the above persons and entities shall be referred to as the "Released Parties" hereafter) who, through negligence, carelessness or any other cause, might otherwise be liable to Sponsor or Student under theories of contract or tort law except for any liability arising from intentional actions or gross negligence by released parties. Sponsor intends by this Waiver and Release to release, in advance, and to waive his or her rights and discharge each and every one of the Released Parties, from any and all claims for damages for death, personal injury or property damage which Sponsor may have, or which may hereafter accrue as a result of Student's participation in any aspect of the Programs, even though that liability may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective property or equipment owned, maintained or controlled by them or because of their possible liability without fault. Except for any liability arising from intentional actions or gross negligence by released Additionally, Sponsor covenants not to

sue any of the Released Parties based upon their breach of any duty owed to Sponsor or Student as a result of their participation in any aspect of the Programs. Sponsor understands and agrees that this Waiver and Release is binding on his or her heirs, assigns and legal representatives and that the Released Parties shall be exempt from liability to Sponsor, his or her heirs, assigns and legal representatives.

Student is physically capable of participating in the Programs, and his or her medical care provider has approved his or her participation. If Sponsor is aware that Student is under treatment for any physical infirmity, ailment or illness, Student's medical care provider knows of and has approved Student's participation in the Programs. Sponsor acknowledges that Sponsor, and Sponsor alone, is solely responsible for Student's personal health and safety, and the personal property Student brings with him or her. Sponsor acknowledges that the medical insurance information Sponsor has provided on the Medical Form is current and complete and that Sponsor is solely responsible for procuring and maintaining all medical insurance Sponsor deems necessary and that the Released Parties have recommended that Sponsor procures and/or maintains medical insurance. Sponsor accepts full responsibility for any costs incurred for medical treatment due to failure to procure or maintain insurance, or providing outdated or falsified insurance information. Sponsor understands that it is ultimately Sponsor's responsibility to provide payment to any hospital/emergency response technicians/emergency transport company that may provide services to Student as a result of injury/illness during the Programs. Sponsor agrees that this Release extends to all claims of every nature and kind whatsoever, and hereby expressly waives all rights under California Civil Code section 1542 which provides as follows:

"A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor." Sponsor agrees to indemnify the Released Parties from any and all actions, causes of action, claims, demands, damages, costs (including attorneys' fees), expenses, liabilities and charges, known or unknown (the "Liabilities") arising out of or in connection with claims and/or actions relating to or brought by or on behalf of Student, including, without limitation, claims related to or arising out of the Minor's participation in the Program. **Initials:** _____.

6. AUTHORIZATION FOR MEDICAL CARE AND RECORDS. In the event of an accident, injury, illness, or other medical necessity, Sponsor hereby authorizes SUWS to: (a) provide emergency first aid to the Student in the field and enroute to any hospital or clinic, (b) arrange for any medical, dental, psychiatric, hospital, ambulance or other health-related care for the Student deemed necessary by SUWS ' staff; and (c) authorize a physician, dentist or other health-care professional(s) to perform any procedure(s) that the health-care professional(s) deems necessary for the well-being of the Student. All costs and expenses incurred for these services shall be the sole responsibility of the Sponsor. Sponsor also authorizes SUWS to arrange for a physical examination (including a drug screen urine/blood test, at SUWS ' option) and any psychological assessments of the Student deemed necessary by SUWS prior to the Student's beginning the Program. Sponsor also authorizes any and all medical doctors, psychiatrists, psychologists, counselors, therapists, hospitals, clinics and treatment centers that have treated or counseled the Student, and whose names Sponsor shall provide to SUWS, to release all information regarding the Student's medical and/or psychological history, diagnoses and treatments to SUWS upon request. SUWS shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") Act of 1996.

7. AUTHORIZATION FOR SEARCH AND SEIZURE. Sponsor hereby authorizes SUWS personnel to search the person and personal effects of the Student at any time, including a "strip search." In connection with such search, SUWS may, in its discretion, require Student to remove all of his or her clothing and may search Student's entire person, in which contraband may be hidden. SUWS is further authorized to confiscate any and all items deemed by SUWS to be contraband or counterproductive to the Student's successful completion of the Program. The disposition of all items confiscated by SUWS shall be left to the sole discretion of SUWS.

8. AUTHORIZATION FOR RESTRAINT. Sponsor hereby authorizes SUWS personnel to physically restrain, control and detain the Student by the exercise of necessary restraints when deemed necessary by SUWS , for purposes including but not limited to escorting the Student to and from the Program's location, returning the Student to the Program if the Student runs away, or preventing the Student from jeopardizing the Student's own safety or the safety of others. In the event of a runaway, all appropriate law enforcement agencies or security personnel of any federal, state, county or municipal entity are hereby directed to detain and retain custody of the Student until Sponsor or any personnel of SUWS arrive, at which time SUWS personnel may re-obtain custody or control of the Student or authorize continued custody by the law enforcement agency until travel is arranged for the Student's return home.

9. RESEARCH AUTHORIZATION. Sponsor hereby authorizes SUWS to use data from the Student's records, tests, and assessments for purposes of ongoing research, provided that the Student's name and identity will be kept confidential and not used in any published materials.

10. EARLY TERMINATION BY SUWS /LIQUIDATED DAMAGES. SUWS reserves the right to terminate this Agreement at any time due to: (i) failure of Sponsor to pay any amounts due under paragraph 4; (ii) illegal, uncontrollable, or dangerous behavior by the Student; (iii) discovery of any unprompted or previously unknown physical, medical, mental, or emotional problem(s) of the Student; or (iv) for any other reason if SUWS deems it necessary for the protection of the Student, any other student(s) or the integrity of SUWS' Program. **In the event that SUWS elects to terminate the Student pursuant to the terms of this paragraph, Sponsor understands and agrees that Sponsor forfeits all monies pre-paid to the program.** The forfeiture reflects the recognition that certain costs associated with making the program available to the Student are incurred, whether or not the program is completed, including such items as salaries, inventories, and other general

operating expenses. Therefore, Sponsor understands and agrees that the policy of non-refundable payments and expenses is a reasonable estimate of the losses (i.e., Liquidated Damages) the program incurs with the early termination of Student.

11. SPONSOR EDUCATION PROGRAM AND COOPERATION. Sponsor agrees to attend the seminar for parents and guardians of the students conducted by SUWS during the Program, and to give Sponsor's full cooperation to SUWS personnel throughout the Program, in order to maximize the benefits of the Program for the Student and the Sponsor. Sponsor also agrees to read any educational materials and watch any video programs sent to Sponsor by SUWS, and to fill out and return to SUWS any interactive educational materials, while the Student is in the Program.

12. ESCORTS. If an escort is required to bring the Student to North Carolina for the Program, Sponsor agrees that any escort or escort service used by Sponsor, whether or not Sponsor is referred to the escort by SUWS, is in all respects an independent contractor contracting directly with Sponsor. Sponsor agrees that SUWS bears no responsibility of any kind for any such escort service or the negligence or failure thereof.

13. HEALTH INSURANCE. Sponsor warrants that the Student is presently covered, and will for the duration of the Program be covered, by adequate health insurance covering claims that may arise in connection with any accident, injury or illness that the Student may suffer or incur during the Program. Whatever deductibles or coverage exclusions may apply in a given case shall be satisfied entirely by Sponsor.

14. EMANCIPATION. Sponsor warrants that the Student is a minor, both by age and as a matter of law, that the Student does not qualify under the law as an "emancipated minor," and that the laws of the Student's state of residence permit Sponsor to place the Student in the Program without the Student's consent.

15. DELAYED PERFORMANCE. Except for the obligation to make payments when due hereunder, all other obligations under this Agreement shall be suspended for so long as one or both Parties hereto are prevented from performing hereunder by acts of God/nature, the elements, acts of federal, state or local governments, agencies or courts, damage to or destruction or unavoidable shut-down of necessary facilities, or other matters beyond their reasonable control; provided, however, that any party so prevented from complying with its obligations hereunder shall promptly notify the other party thereof and shall exercise due diligence to remove and overcome the cause of such inability to perform as soon as practicable.

16. ATTORNEY'S FEES. In the event that either party is found in default or material breach of any specific promise, term or condition expressly set forth in this Agreement by an arbitrator(s) or a court of competent jurisdiction, said party shall be liable to pay all reasonable attorneys' fee, court costs and other related collection costs and expenses incurred by the other party in enforcing its contractual rights hereunder in said arbitration and/or court proceeding(s). In addition, Sponsor agrees to compensate SUWS for all reasonable attorneys' fees and costs incurred by SUWS in connection with those matters concerning which Sponsor has agreed to pay or indemnify SUWS herein.

17. NOTICES. Any and all notices, payments, reports and other correspondence required hereunder shall be deemed to have been properly given or delivered when made in writing and delivered personally to the party to whom directed, or when sent by United States mail with all necessary postage or charges fully prepaid, and addressed to the party to whom directed at its below specified address (or a new address after written notice of such change is given to the other party).

SUWS OF THE CAROLINAS	PARENT'S NAME _____
c/o Aspen Education Group	ADDRESS _____
17777 Center Court Drive, Suite 300	CITY, STATE, ZIP _____
Cerritos, CA 90703	

18. AMENDMENTS. This agreement may be amended at any time upon mutual agreement of the parties hereto, but any amendment(s) must first be reduced to writing and signed by both parties in order to become effective.

19. WAIVER. A waiver by any party of any provision hereof, whether in writing or by course of conduct or otherwise, shall be valid only in the instance for which it is given, and shall not be deemed a continuing waiver of said provision, nor shall it be construed as a waiver of any other provision hereof.

20. PARAGRAPH HEADING. The paragraph headings of this Agreement are inserted only for convenience and in no way define, limit or describe the scope or intent of this Agreement nor affect its terms and provisions.

21. GOVERNING LAW/VENUE. This Agreement, and all matters relating hereto, including any matter or dispute arising between the parties out of this Agreement, tort or otherwise, shall be interpreted, governed, and enforced according to the laws of the State of California; and the Parties consent and submit to the exclusive jurisdiction and venue of the California Courts in Los Angeles County, California, and any qualified (American Arbitration Association-approved) arbitration service in the State of California, County of Los Angeles, to enforce this Agreement. The parties acknowledge that this agreement constitutes a business transaction within the State of California.

22. SEVERABILITY. In the event that any provision of this Agreement, or any operation contemplated hereunder, is found by a court of competent jurisdiction to be inconsistent with or contrary to any law, ordinance, or regulation, the latter shall be deemed to control and the Agreement shall be regarded as modified accordingly and, in any event, the remainder of this Agreement shall continue in full force and effect.

23. NUMBER. As used in this Agreement, the term "Sponsor" shall include all Sponsors, being the parent(s) and/or guardian(s) executing this Agreement; and singular pronouns shall include the plural and plural pronouns shall include the singular, whenever the context so requires.

24. ACKNOWLEDGEMENT/ENTIRE AGREEMENT. Sponsor hereby acknowledges that Sponsor has read this Agreement and that Sponsor understands and consents to all of its provisions; that this Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter hereof; and that all other prior agreements, promises, expectations and conditions, oral or written, between the parties are incorporated herein. Other than the express commitments set forth in this Agreement and the Program description, SUWS gives no warranties of any kind, express or implied, to either the Sponsor or the Student concerning the Program; and Sponsor acknowledges that Sponsor is not relying on any warranties or representations of any kind other than the express commitments of SUWS set forth herein.

25. BINDING EFFECT. This Agreement shall be binding upon and inure to the benefit of the parties hereto, their heirs, personal representatives, successors and assigns.

26. RELEASE OF INFORMATION. The parties authorize the release of the Student’s information via E-mail, Internet technology, voice mail or US mail. While every effort will be made to maintain confidentiality, SUWS accepts no responsibility for the mistransmission that could result in information becoming available to someone other than the intended receiver. SUWS shall handle all such protected health information (also “PHI”) pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act (“HIPAA”) Act of 1996.

27. ARBITRATION AGREEMENT. Any controversy or claim arising out of or relating to this contact, except at SUWS of the Carolina’s option the collection of monies owed by sponsor to SUWS OF THE CAROLINAS, shall be settled by binding arbitration conducted in the State of California in accordance with the rules of the American Arbitration Association. Judgment upon the awarded rendered by the arbitrator(s) may be entered in any court of competent jurisdiction for the purpose of executing upon award.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the dates set forth below.

_____ Date: _____
Sponsor (father/guardian)

_____ Date: _____
Sponsor (mother/guardian)

Accepted: _____ Date: _____
SUWS OF THE CAROLINAS

****All financial inquiries can be made to our Finance Manager at 828.668.7590****

EXHIBIT A – Enrollment Agreement

I/we understand that the cost of SUWS of the Carolinas is \$465 per day, \$2,000 enrollment fee, and \$2210 psychological testing fee. I/we understand that there is a minimum initial payment covering the first 28 days of the program for a total of \$17,230 unless I choose to opt out of the psychological testing fee making the initial payment of program to be a total of \$15, 020. I/we further understand that if our child remains enrolled in the program beyond the initially, indicated length of stay that **ALL EXTENSIONS ARE BILLED AT A DAILY RATE OF \$465.00 PER DAY, AND ALL EXTENSIONS ARE BILLED TO A CREDIT CARD.**

*****INCIDENTAL EXPENSES**

Please include a credit card number below as all extensions and incidental expenses will be charged to this number, unless prior arrangements have been made.

Number: _____ **Exp:** _____ **3 digit security code:** _____

GRADUATION IS ALWAYS ON A WEDNESDAY. To calculate the initial length of stay, start with your date of enrollment plus chosen length of stay and add days until reaching and including the next Wednesday. Please complete the following to indicate initial payment.

Optional Tuition Calculation Formula for Initial Length of Stay:

1. 28 days + ____ days more that I'd like to prepay for, including date of enrollment and through (and including) a Wednesday = _____
2. ____ (Days from above total) X \$465.00 + \$2000.00 + \$2210.00 _____
3. Plus Credit Card Number for all Extensions and incidental expense deposit
4. Total – Line 2 _____

Please indicate methods of payment:

- Check** (payable to SUWS of the Carolinas, c/o finance, 363 Graphite Road, Old Fort, NC 28762)
- Credit Card**
Amex/Visa/MasterCard Account Number: _____ Exp: _____
3 digit security code: _____
Authorized Signature: _____ Date: _____
- Wire Transfer** (please call our financial manager for this information at 828-668-7590)
- Educational Loan**
Date Loan applied for: _____ Pre-Qualification Date: _____ Loan Amount: _____

My signature below is a formal application to participate with SUWS of the Carolinas and an understanding of its physical demands. I agree to not sue, to assume all risks and to release and hold harmless AEG and any and all of its predecessors, successors, officers, directors, trustees, insurers, employees, managers, agents, volunteers, community organizations, administrators, heirs, attorneys, executors, assigns and/or related or affiliated business entities including, but not limited to AEG. We understand and agree that this Waiver and Release is binding on our heirs, assigns and legal representatives and that the Released Parties shall be exempt from liability to us, our heirs, assigns and legal representatives. _____ initial

1. I understand that even though the program works extremely well, results are not and cannot be guaranteed.
2. **SUWS of the Carolinas charges for the length of stay your child remains in our custody. Any unused portion of the tuition will be refunded. Tuition charges apply to any day a child is in our care.**
3. Please note, until we have received your complete application and/or any testing, we cannot assure your child a space for the week requested.
4. Payment must be received prior to course starting date.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Social Security Number (VERY IMPORTANT!) _____

Participant's Name _____

<h1 style="margin: 0;">SUWS OF THE CAROLINAS</h1> <h2 style="margin: 0;">SAFETY PROVISIONS & PARENT AUTHORIZATION & CONSENT</h2>
--

Inasmuch as I have enrolled my son/daughter (full name) _____ in the SUWS OF THE CAROLINAS Adolescent Program beginning (date) _____ until graduation, and understanding that the program to be conducted in North Carolina is a rigorous physical and emotional experience for youth, and realizing that SUWS has exclusive control of (full name) _____ during this time, I approve and consent to the following safety procedures to ensure the well-being of all participants:

- Should a parent, legal guardian, or a child have a grievance, they should be encouraged to speak directly with the Field Supervisor or Clinical Director to resolve the grievance. Any issues that a client believes have not been satisfactorily addressed can be directed to the director of the program. In the event that this issue cannot be resolved please contact Sue Crowell, Vice President of the Aspen Education Wilderness Division, at 888-828-9770
- That SUWS personnel have my permission to review, return, or restrict all incoming/outgoing mail to/from my child.
- That all medical personnel of any hospital or other appropriate medical facility shall have authorization to provide emergency medical treatment according to their professional discretion during the course of the expedition.
- That any and all psychologists, medical doctors, hospitals, counselors, therapists, or others who have counseled or treated my/our child, and whose names have been provided to SUWS on the Parent Concern Questionnaire, are hereby authorized to release all information regarding medical history, diagnosis, treatment, or disability to SUWS staff and consultants who will be involved in my/our child's program.
- Should our son/daughter run away from the control and supervision of the SUWS staff during the term of the SUWS program, all appropriate law enforcement or security personnel of any federal, state, county, or municipal entity shall be directed to detail and retain custody of my/our son/daughter until my spouse or I or any SUWS personnel are contacted, at which time SUWS personnel may re-obtain custody or control of him/her, or they may authorize continued custody by the entity until travel is arranged for his/her immediate return to my/our home.
- That SUWS personnel shall be able to physically restrain, control, and detain my/our child for the following purposes:
 - a) To prevent from running away from SUWS supervision, jeopardizing his/her safety and that of other students.
 - b) To detain him/her if for any reason he/she leaves the group and attempts to return home through any means of transportation. This detention shall be for a period of time until SUWS personnel have made telephone contact with me or my spouse, at which time a decision will be made to continue the expedition or return him/her home immediately.
 - c) To prevent him/her from hurting or jeopardizing the safety of anyone in the program.

It is understood that any physical restraint will be the minimum required and will only be used to ensure his/her safety.

Printed Names -- Mother	Father	Date
-------------------------	--------	------

Signatures -- Mother	Father	Phone Number
----------------------	--------	--------------

Full Address	City	State	Zip
--------------	------	-------	-----

Full Address	City	State	Zip
--------------	------	-------	-----

AFTER CARE TRANSITION SPECIALIST DISCLOSURE



The Aftercare Transition Specialist provides the following:

Education on Continuum of Care: Broad overview of the possible next steps and resources available to you and your child following the wilderness program.

Proactive Planning: Information about how to prepare for a successful transition following your child's wilderness experience whether the next step is a residential treatment center or transition home with aftercare support. Preparation and forethought prior to having to make this decision allows for a more effective transition for everyone and helps to preserve the current investment made by you and your child.

Integration of Service Providers: Collaboration and communication helps minimize the risk of disruption and/or regression as your child moves from one environment to the next. By beginning the process of coordinating these resources prior to discharge, you and your child are better prepared to continue the progress that is made during the wilderness experience.

CONSENT FOR DISCUSSION AND RELEASE OF PROTECTED HEALTH INFORMATION

I hereby agree to allow an Aftercare Transition Specialist to participate in a discussion of treatment options for the child named below. I understand that this discussion(s) may be with educational consultants, mental health professionals, and institutions. I also understand that the purpose of this conversation is solely for providing aftercare resources following my child's discharge from the wilderness program. Treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required by law.

I understand that there is no cost associated with this discussion. The Protected Health Information that may be discussed may include *medical history, mental, physical condition, treatment, and financial* related information. Aspen Education Group has my permission to release information to the Aftercare Transition Specialist

Name of Minor: _____ Relationship to Minor: _____

Name of Parent or Guardian (Print) _____

Signature: _____ Date: _____

This authorization expires: _____

NOTICE OF RIGHTS

Check the below boxes (indicates your understanding)

- It is noted that I may refuse to sign this Authorization at anytime.
- I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address:
Program's address: _____
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization
- I understand that I have a right to receive a copy of this Authorization
- I understand that the information to be released or disclosed may include those relating to sexually transmitted diseases, AIDS or HIV, alcohol / drug / substance abuse under 42 CFR 2.311 authorize the release or disclosure of this information after having specifically considering and expressly waiving those federal consent requirements and restrictions

AFFILIATE PROGRAMS OF ASPEN EDUCATION GROUP

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with State and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

I/we authorize SUWS OF THE CAROLINAS to release any and all information to the referral source listed on the application and all aspen education Group program. I/We authorize the below named educational consultants, professional and/or institutions to release and receive all information concerning the student named below to and from SUWS OF THE CAROLINAS and all AEG Programs. Information should include as much of the following as would be helpful in providing additional assessment and continuation of care: medical/treatment history, psychological evaluations, discharge summaries, progress case notes and/or academic record.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____

Persons/Organizations authorized to *use or disclose* the information: 1 PARENTS, SUWS OF THE CAROLINAS \

Persons/Organizations authorized to receive the information: SUWS OF THE CAROLINAS,

REFERRAL SOURCE: _____

AGENCY/INSTITUTION: _____

ADDRESS _____

ADDRESS _____

CITY STATE ZIP _____

CITY STATE ZIP _____

PHONE/FAX _____

PHONE/FAX _____

/
INCLUSIVE DATES OF TREATMENT _____

/
INCLUSIVE DATES OF TREATMENT _____

INSURANCE COMPANY: _____

AGENCY/INSTITUTION: _____

ADDRESS _____

ADDRESS _____

CITY STATE ZIP _____

CITY STATE ZIP _____

PHONE/FAX _____

PHONE/FAX _____

/
POLICY NUMBER _____

/
INCLUSIVE DATES OF TREATMENT _____

Purpose of requested use or disclosure: 2 Treatment

This Authorization applies to the following information (select *only one* of the following): 3

All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: _____

Only the following records or types of health information (including any dates): _____

EXPIRATION

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: ATTN: Admissions 363 Graphite Road Old Fort NC 28762

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.⁵

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIP AA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: 7 _____

Witness: _____

Please Note: A Representative from SUWS of the Carolinas will be able to sign as a witness once we receive the paperwork

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.)

- 1 If the Authorization is being requested by the entity holding the information, this entity is the Requestor.
- 2 The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- 3 This form may not be used to release both psychotherapy notes and other types of health information (see 45 CFR § 164.508(b)(3)(ii)). If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.
- 4 If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.
- 5 Under HIP AA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR § 164.508(d)(1), (e)(2)).
- 6 If any of the exceptions to this statement, as recognized by HIP AA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the

individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

7 The requestor is to complete this section of the form.

NOTICE OF PRIVACY PRACTICES
OF
ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Human Resources Manager.

WHO MUST FOLLOW THE REQUIREMENTS OF THIS NOTICE?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Aspen Education Group and its affiliated entities (collectively, "Aspen") must take steps to protect the privacy of your "protected health information" (referred to in this Notice as "PHI" or "health information"). PHI includes information that we have created or received regarding your health or payment for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Aspen Education Group is an organization that is committed to improving the quality of life for youth and their families. Aspen operates 31 programs in nine states that provide innovative quality educational programs that promote academic and personal growth. The services provided by Aspen's programs are diverse and, in some cases, the provision of health care treatment and services may be the primary function – for example, the provision of mental health services by Aspen Community Services – or, in other cases, the provision of health care treatment may be a secondary or ancillary function -- for example, a nurse's office located on an Aspen school campus. Aspen also operates an employee benefit health plan for the benefit of its employees.

All of these programs, functions and services operated or provided by Aspen are conducted through separate but affiliated entities which are identified on Exhibit B attached to this Notice. Under the privacy standards contained in HIPAA, legally separate but affiliated entities may designate themselves as a single covered entity for compliance purposes. Accordingly, this Notice constitutes notice of the privacy practices for all of the Aspen-affiliated entities, sites and locations that are listed on the attached Exhibit B, which will follow the terms of this Notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment or health care operations purposes as described in this Notice. All Aspen employees are required to maintain the confidentiality of PHI in accordance with this Notice and receive appropriate privacy training.

Please note, however, that this Notice of Privacy Practices does not apply to student medical records that are maintained by Aspen's four special education day schools in Southern California -- Hawthorne Academy, Rossier Park High School and Elementary School, and Leeway School. The reason is that these schools are subject to the Federal Educational Rights and Privacy Act ("FERPA") resulting from their receipt of indirect funding from the U.S. Department of Education. The privacy rights and protections afforded to student medical records maintained by those schools will be governed by FERPA instead.

RESPONSIBILITIES OF ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES

We are required by law to:

- Make sure that health information that identifies you is kept private (with certain exceptions);
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of this Notice that are currently in effect.

This Notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT DO NOT REQUIRE YOUR AUTHORIZATION

Aspen uses and discloses protected health information in a number of ways connected to the provision of health care treatment and services, payment for care, and our health care operations. Some examples of how we may use or disclose your health information without your authorization are listed below.

We may use or disclose your protected health information without your authorization as follows connected to the provision of health care treatment and services:

- To physicians, nurses, and others involved in your health care or preventive health care.
- To other health care providers treating you such as hospitals, pharmacies, labs, emergency room staff and specialists. For example, if you are being treated for an injured knee, we may share your health information among your primary physician, the knee specialist, and your physical therapist so they can provide proper care.

We may use or disclose your protected health information without your authorization as follows in relation to payment for care:

- To administer your health benefits policy or contract (for Aspen Education Group Employee Benefit Plan members).
- To bill you for health care we provide.
- To pay others who provided care to you.
- To other organizations and providers for payment activities unless disclosure is prohibited by law.

We may use or disclose your protected health information without your authorization as follows in relation to health care operations:

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your health information to review and improve the quality of care you receive, to provide training, and to evaluate the performance of our staff in caring for you.
- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your health information with other organizations for this purpose, they must agree to protect your privacy.)

We may use or disclose your protected health information without your authorization for legal and/or governmental purposes in the following circumstances:

- As required by law -- When we are required to do so by federal, state or local law.
- Public health and safety -- To an authorized public health authority or individual for public health and safety purposes, including to:
 - Protect or prevent a serious threat to the health and safety of the public or of another person.
 - Prevent or control disease, injury, or disability.
 - Report vital statistics such as births or deaths.
 - Report reactions to medications or problems with products and notify people of recalls of products they may be using. (Food and Drug Administration.)
 - Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
 - Notify an employer concerning work-related injuries or illnesses or workplace medical surveillance in situations where the employer has a duty under federal or state law to keep records on or act on such information.
- Abuse or neglect -- To the appropriate government authority authorized to receive reports regarding abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law. However, no consent is required in cases involving child abuse or neglect.
- Health oversight activities -- To health oversight agencies for certain activities such as audits, investigations, inspections and licensure.
- Lawsuits and disputes -- In the course of any legal proceeding, in response to an order of a court or administrative agency. Also, in certain cases, in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- Law enforcement -- To law enforcement officials in limited circumstances for law enforcement purposes. For example disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.
- Military activity and national security -- To the military (if you are a member of the armed forces), and to authorized federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.
- Workers' compensation -- Where authorized by law in order to comply with the workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

We may also use or disclose your protected health information without your authorization in the following miscellaneous circumstances:

- Facility directory information -- Unless you object, we may use and disclose your name, the location at which you are receiving care, your general condition (e.g., fair, stable, etc.), and your religious affiliation in our facility directory. All of this information except religious affiliation will be disclosed to people who ask for you by name. Members of the clergy (such as a priest or rabbi) will be told your religious affiliation if they ask (but they don't have to ask for you by name). This is to help your family, friends, and clergy visit you in the facility and generally know how you are doing.
- Family and friends -- Unless you object, we may disclose health information about you to a family member, relative, a close friend - or any other person you identify who is directly involved in your health care - who is involved in your care or who helps pay for your care. If you are either not present or unable to make a health care decision for yourself and we determine that disclosure is in your best interest, we may also disclose such health information about you to those persons. For example, we may disclose health information to a friend who brings you into an emergency room.
- Appointment reminders -- To remind you that you have a health care appointment with us. These reminders may be made by postcard, phone, or voicemail unless you specifically ask us to communicate with you through a different method as described later in this Notice.
- Treatment alternatives and health-related services -- To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you.
- Employer group health plans -- For Aspen Education Group Employee Benefit Plan members, we may communicate with your employer for certain administrative activities.
- Health insurance underwriting -- For Aspen Education Group Employee Benefit Plan members, we may use your health information for underwriting, premium rating or other health insurance-related activities
- Research - For research purposes provided that certain steps are taken to protect your privacy. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility
- De-identify information -- To "de-identify" information by removing information from your health information that could be used to identify you.
- Disaster relief -- To an authorized public or private entity for disaster relief purposes. For example, we might disclose your health information to help notify family members of your location or general condition.
- Coroners, funeral directors, and organ donation -- To coroners, funeral directors, and organ donation organizations as authorized by law.
- Correctional institution -- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official for certain purposes, such as (1) providing health care to you by the institution; (2) protecting your health and safety or the health and safety of others; or (3) protecting the safety and security of the correctional institution.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT REQUIRE US TO OBTAIN YOUR AUTHORIZATION

Except in the situations listed in the sections above, we will use and disclose your health information only with your written authorization. If you sign an authorization you may revoke it at any time in writing, although this will not affect information that we disclosed before you revoked the authorization. If you would like to ask us to disclose your health information, please contact the Aspen Privacy Officer at (562) 467-5500 for an authorization form. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the right to:

- Restrictions on use or disclosure -- Request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Please note that we are not required to agree to your request. If we do agree, we will honor your limits unless it is an emergency situation. To request restrictions, you must make your request in writing to the Aspen Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- Confidential Communications -- Request that we communicate with you about health matters by another means or at another location. For example, if you want us to communicate with you at a different address we can usually accommodate that request. Any request must be made in writing to the Aspen Privacy Officer. Your request must specify how or where you wish to be contacted. We will agree to reasonable requests.
- Inspect and copy -- Inspect and copy health information that may be used to make decisions about your care. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Aspen Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.

Amend -- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Aspen. To request an amendment, your request must be made in writing and submitted to the Aspen Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Aspen;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

- Accounting of disclosures -- Request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, (as those functions are described above) and for other exceptions pursuant to the law. To request this list or accounting of disclosures, you must submit your request in writing to the Aspen Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Paper copy -- Request a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper
- copy of this Notice.

CHANGES TO PRIVACY PRACTICES

Aspen may change the terms of this Notice at any time. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. If we change any of the practices described in this Notice, we will post the revised Notice on enrollee-accessible web sites and at Aspen clinic sites. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Aspen or with the Secretary of the Department of Health and Human Services. To file a complaint with Aspen, write to Ruth Moore, Vice President, Corporate Compliance, at 17777 Center Court Drive, Suite 300, Cerritos, CA 90703. For more information on how to file a written complaint, contact the Aspen Privacy Officer at (562) 467-5500. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

QUESTIONS

If you have any questions about this Notice or would like an additional copy, please contact the contact the Aspen Privacy Officer at (562) 467-5500.

NOTICE OF PRIVACY PRACTICES
OF
ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Aspen Education Group and its affiliated entities. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our Notice, you may request a copy of the revised notice by accessing our web site (<http://www.aspeneducation.com>) or contacting our organization at (562) 467-5500. If you have any questions about our Notice of Privacy Practices, please contact Aspen's Privacy Officer at (562) 467-5500.

I acknowledge receipt of the Notice of Privacy Practices of Aspen Education Group and its Affiliated Entities.

Signature: _____
(individual/parent/conservator/guardian)

Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

[To be completed only if no signature is obtained]

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Aspen representative _____ Date: _____



SUWS of the Carolinas · 363 Graphite Rd, Old Fort, NC 28762 · 888.828.9770

PSYCHOLOGICAL AND PSYCHOEDUCATIONAL TESTING

A comprehensive battery of psychological testing is a standard at SUWS of the Carolinas. SUWS of the Carolinas is committed to providing the most innovative and effective services, which includes developing a treatment plan that is unique to your child or adolescents' needs. Many behavioral, mental health and/or learning problems share similar symptoms and behaviors; however, because the underlying factors can vary significantly, it is often very beneficial to obtain a comprehensive evaluation. The comprehensive evaluation can assist in clarifying diagnoses, identifying *strengths* and weaknesses, identifying potential risk factors, and ultimately formulating a successful treatment plan through improved understanding of the complex interplay between emotional, behavioral, cognitive, personality, and/or learning issues.

All psychological testing is conducted or supervised by doctoral level psychologists, who are contracted through the Center for Research, Assessment, and Treatment Efficacy (CReATE) in Asheville, NC (www.createnc.com). The psychologists of CReATE use evidence-based assessment approaches in the evaluation of various mental health and behavioral conditions. They will provide a comprehensive verbal explanation to the parent(s) about the testing results as well as a comprehensive written report of all findings. The written report includes explanations of the tests used, results, a comprehensive psychosocial history, a summary and diagnostic formulation, and recommendations for treatment, intervention, education, and/or after-care planning. They will also consult with your child or adolescent's therapist at SUWS as well as other professionals who may be involved in the care of your child or adolescent, before or after SUWS, as deemed appropriate.

CONSENT TO ADMINISTER PSYCHOLOGICAL TESTING

I hereby agree to psychological testing for the child named below. I understand that all test protocols and all material generated from the assessment are the property of the SUWS of the Carolinas Program. I understand that information may come to light during this evaluation that must remain confidential, due to the content of the disclosure. I understand that the results of the assessment will be used by the staff of SUWS Programs to enhance the treatment of the child named below. SUWS has my permission to release information to any professional who is working with my child. Finally, I understand that no information will be shared with anyone else, or any other agency, without my permission.

Fee: \$2210.00 (In addition to program tuition)

Name of minor child: _____ Relationship to minor: _____

Name of parent or guardian: _____

- Payment by Credit Card (Visa, MasterCard, or American Express)
Card Number: _____ Exp Date: _____ CVV: _____
- Cashiers Check (payable to SUWS of the Carolinas, c/o Admissions, 363 Graphite Rd, Old Fort, NC 28762)
- Wire (contact Admissions Department at 877-305-0904)

No, I do not wish to have my child evaluated at this time.

Signature: _____ Date: _____

If your child has recently had testing, a partial battery of tests may be available. Please talk to your child’s therapist to find out more

SUWS OF THE CAROLINAS - PARENT WORKSHOP

Parents are encouraged to attend this engaging two-day, activity-based workshop led by Dr. Brooke Judkins, the Family Program Coordinator at SUWS of the Carolinas. Designed to complement the Trail’s End experience, it provides educational and community support for parents during their child’s stay at SUWS of the Carolinas. Workshops take place at the Wolf Creek Lodge and recommendations for area lodging will be provided. It is recommended that parents attend a workshop when their child is mid-way through the program (around weeks 3, 4, or 5). The workshop fee is \$250 per parent.

CONSENT TO PARTICIPATE IN PARENTING WORKSHOP

Fee: \$250.00/parent (In addition to program tuition)

Name of parent or guardian: _____

- Payment by Credit Card (Visa, MasterCard, or American Express)
Card Number: _____ Exp Date: _____ CVV: _____
- Cashiers Check (payable to SUWS of the Carolinas, c/o Admissions, 363 Graphite Rd, Old Fort, NC 28762)
- Wire (contact financial manager at 828-668-590)

No, I do not wish to participate in the Parent Workshop

Signature: _____ Date: _____

SUWS OF THE CAROLINAS

Vegetarian: (circle one) **Yes No Special Dietary Needs Yes No** If Yes, Please Explain:

Does your Child Require the Following: (Please Circle Appropriate Answer)

Prescription Eyewear Yes No Glasses are Required, (Please send in Case)

Dental Retainer Yes No Please Send Container

Please List Any Additional Information that is NECESSARY for your Child's Care:

Contact Information: Father: _____ Mother: _____

Hm Ph: _____ Hm Ph: _____

Wk Ph: _____ Wk Ph: _____

Cell Ph: _____ Cell Ph: _____

Arrival Information- Are You flying driving

Airline: _____ Flight: _____ Arrival Time: _____ Escort: .

City of last leg of flight arriving from/ or meeting place (driving) : _____ Color of carry-on bag: _____

Dear Parents,

This is a very important note regarding prescription and over the counter medications. Following these instructions will ensure your child has no interruptions in their medication regimen.

- Please ensure your child arrives with at least a month's supply of his or her medications.
- We are required by the law to administer medications as the prescription reads on the bottle. If you administer your child's medications differently than the bottle reads, please include a note from a physician outlining the new instructions.
- All medications must be accompanied by a written prescription or medical authorization from the prescribing physician. The authorization or doctor's note must include the name of the child, the medication, the dosage, directions for administration, the date, and the physician's signature.
- If your child will be arriving with vitamins, supplements, or over the counter medications, please include a detailed note outlining instructions for administration.
- All over-the-counter meds must accompanied by a prescription or note from the doctor.
- Please ensure that we have a copy of both your child's health insurance card as well as their prescription card.

Thank you,

SUWS of the Carolinas Health Team



PSA Pharmacy
2294 US Highway 70
Swannanoa, NC
Phone 828-686-3804 Fax- 828-686-3839

PSA pharmacy is a locally owned, independent pharmacy specializing in servicing the pharmaceutical needs of patients in long-term care, boarding schools and other facilities, as well as at home. Our pharmacists have over 150 years of combined experience providing care to residents of Western North Carolina.

PSA Beverly Hills Pharmacy provides facility residents with all of their medication needs and works with facility personnel to ensure medication safety.

Our services include:

- Delivery Service
- Medication Therapy Management Services by specially trained pharmacists.
- Specialized medication packaging to ensure safety and accuracy
- Prescription and non-prescription medications at competitive prices, including generically equivalent drugs
- Consultant Pharmacist-reviewed medication profiles
- Nursing and Med-tech in-services, including topics such as proper medication storage, med-pass, and new-drug updates.
- Computerized clinical records for your medical and nursing team
- Monthly billing statements
- Delivery of medications one or more times daily, and immediately for urgent needs.

PSA Pharmacy has been providing care to patients in the Asheville-Buncombe County area for the past 35 years and enjoys an excellent relationship with Community Care Partners and Mission Hospital.

We have had the pleasure of being the Mountain Area Hospice's pharmaceutical care provider since 1997 and have been providing pharmaceutical services to health care facilities since 1998

Pharmacists:

Mike Tolley, RPh- Site Manager

William F. Horton, RPh. – Staff Pharmacist Pharmaceutical Care Specialist

Teresa Pearman, RPh – Staff Pharmacist Retail Pharmacy Specialist

Everett Dunn, RPh – Consultant Pharmacist – Long Term Care and Geriatric Specialist

Pharmacy Techs:

Kelly Hamlin – Opus Specialist

Lori Rice – Group Home Specialist

Laura Camby- Retail Specialist

Sarah English Grindstaff- Third Party Insurance and Billing

Drivers:

Roby Dotson

Peter Clarke

Lawrence Bartlett (Bud)

Clyde Roberts



PSA Pharmacy
2294 US Highway 70
Swannanoa, NC
Phone 828-686-3804 Fax- 828-686-3839

PSA Pharmacy will be providing pharmacy services for your child while he or she is attending SUWS .

Your child will arrive at SUWS with their medicine. We will supply medications needed when that supply is exhausted and will fill a month's supply at a time.

To insure that your child gets their medication when needed, we need for you to supply the following to SUWS when you complete their admission forms:

- A **legible** copy of your **prescription drug plan card**, front and back. Please note that insurance and prescription cards may be different. The Prescription Drug Card should have an **ID number, Person Number (if any), Rx Group Number, "BIN" Number, "PCN" Number, and Toll Free Telephone Number** for the Pharmacy Benefits Payor. Be careful to supply the correct card.
- A **VISA or MASTER CARD** Number with expiration date. (Discover and Amex not acceptable)
- Complete and sign the **PHARMACY CONTRACT**
- Have your son or daughter's physician write a prescription for any medications that will be needed and send original documents to pharmacy. Non-control prescriptions may be faxed.

We will electronically bill your insurance plan and you will be billed for any co-pay. We will make every effort to collect from your insurance company, however having clear and accurate information as well as a clear and legible copy of your card is vital. If for any reason your insurance company fails to pay or declines payment, we will bill you the cash price and you will be responsible for the full amount. If this happens, we will provide you with all information necessary for you to pursue filing a paper claim and seeking re-imbusement from your plan.

In addition to the prescription price or co-pay, we will also charge \$1.00 per Standard Unit Dose Card or \$3.00 for a 4 part Unit Dose Card for packaging and a dispensing fee of \$5.00 per Rx (Maximum of \$15.00 per month) to cover the cost of delivery and other ancillary services provided by us (e.g. monthly billing and medical records service) We will charge your credit card the day we provide medicine and mail you a receipt as well as a detailed statement.

Should you have any questions regarding your son or daughter's medications please contact one of our pharmacists. For billing questions, contact Sarah Grindstaff.

CUSTOMER AGREEMENT

To have us provide billing services on your behalf, please complete entire form

Facility Name: SUWS of the Carolinas		
Customer Name:	SS#	HIC#
Billing Address:	Insurance ID#	DOB / /
Insurance Company:		

REMINDER- Please attach legible copy (front and back) of Prescription Drug Card

An itemized list of charges along with credit card receipts showing payment will be mailed to you upon discharge.

Request for Provision of Service

I understand that by signing this agreement, I indicate my desire to purchase health care products and services from PSA Pharmacy

Indication of Medical Responsibility

I agree to the following:

The person from whom pharmacy services are provided is under the supervision and control of a physician. The physician has prescribed medication, therapy, equipment or supplies as a part of the treatment plan for this person. The physician is solely responsible for diagnosing and prescribing drugs and therapy appropriate to the patient's diagnosis and for otherwise supervising and controlling the medical care of the patient.

Agreement to Pay

The undersigned parent/guardian/guarantor/trustee or legally responsible representative agrees to pay PSA Pharmacy for all products and services provided to the customer. In addition, the undersigned agrees to be responsible for full payment of charges:

If third party insurance payors do not make payment for claims submitted on behalf of the customer

If PSA Pharmacy does not accept the customer's insurance plan

If the customer utilizes PSA Pharmacy for emergency supplies

If any collection agency or attorney's fees are incurred to collect any customer account

If the customer or responsible person fails to supply within 7 days the information needed to submit claims to insurance

In the event that a facility or caregiver authorizes consent on behalf of the customer, any charges must be paid from the customer's funds/estate/ or other resources.

Assignment of Benefits

The undersigned hereby authorizes PSA Pharmacy to request and collect all public and private insurance coverage benefits due for the products and services supplied to the customer by PSA Pharmacy. In the event that payment for insurance benefits is made directly to any of the undersigned, the payee will immediately endorse all checks for such payments to PSA Pharmacy.

Release of Information

The undersigned authorizes the insurer(s) and any other third party payer who provides the customer with coverage to disclose to PSA Pharmacy and information regarding such coverage, including but not limited to: payment made by such insurer(s) or third party payer(s) to any of us, for therapy or service rendered to the patient by PSA Pharmacy and the scope and extent of coverage available from time to time. Customer authorizes all medical personnel to provide information to PSA Pharmacy concerning his/her medical history, as may relate to the customer's therapy.

The undersigned consents to the review of the customer's records including medical records by any federal, state, or accredited body as required by the regulatory, licensing, or accrediting body.

The undersigned certifies that he/she has read the foregoing and has received a copy of this agreement. The undersigned also certifies that he/she is authorized as the customer's agent to execute the above and accepted terms. Note: A duplicate copy of this agreement shall be considered the same as the original.

Responsible Representative's Signature: _____ **Date:** _____

Relationship to Customer: _____

Address: _____ **Phone#** _____

Credit Card Information: VISA MASTER CARD **Name on Card:** _____

Credit Card Number: _____ **Credit Card Expiration Date:** _____

Three Digit Security Number (on back of card near signature) _____



MEDICATION AUTHORIZATION

Please provide the following information:

Physician Name:	Phone:																								
Physician's Address:																									
Student Name:																									
I hereby authorize SUWS of the Carolinas to make available the following prescription and/or non-prescription medications for the following student mentioned above.																									
<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width:33%;">Name of Medication</th> <th style="width:33%;">Dosage</th> <th style="width:33%;">Directions</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		Name of Medication	Dosage	Directions																					
Name of Medication	Dosage	Directions																							
Parent or Legal Guardian Signature: _____ Date: _____																									
Physician Signature: _____ Date: _____																									

DECLARATION OF PERSONAL AND MEDICAL INFORMATION: I declare that the personal and medical information that I have supplied throughout the application is complete and correct. This form must be filled out in its entirety and signed by prescribing physician before medications may be administered. In the result that this form is unavailable, the student will be taken to Biltmore Psychiatry to be evaluated and necessary medications signed off. **Please note there is a \$250 charge for this visit.**

**SUWS of the Carolinas
 SUWS Seasons &
 Phoenix Outdoors
 Over The Counter Medications**

We have the following over the counter medications available for your child while he/she is a student in our program. We need your permission in order to administer these medications if they are needed.

Student Name: _____

PLEASE MARK YES OR NO ON THE FOLLOWING MEDICATIONS

Medication	Yes	No
Cold Medicines- Medi-phenyl, CCP, Thera flu	_____	_____
Allergy medicines- Diphen, Loratadine, benedryl cream	_____	_____
Multi Vitamins- Cranberry pills	_____	_____
Ibuprofen, acetaminophen	_____	_____
Diamode, pepto bismal Diotame, antacids, metamucil	_____	_____
Antibiotic ointment, Burn cream Vit A&D, Antifungal, Hydrocortisone	_____	_____
Epi-Pen	_____	_____
Albuterol inhaler	_____	_____
Ivy X, After bite	_____	_____
Bens bug spray 100% DEET	_____	_____
Hand Sanitizer, lotion Powder	_____	_____

Parents Name: _____ Date: _____
 Printed

Parents Name: _____
 Signature

ORDER	RECOMMENDED USE	DOSE/ROUTE	INSTRUCTIONS
Antibiotic ointment Burn cream	Use for minor cuts, scrapes, burns, to help prevent infection	TOPICAL Apply to affected area 1 to 3 x a day	Do not use in the eyes or over large areas of the body
Vitamin A & D ointment	Temporary protection of chafed, chapped or cracked skin	TOPICAL Use liberally as often as needed	Avoid contact with eyes, Do not apply over deep puncture wounds or infections.
Antifungal Cream	For use in treatment of athlete's foot, ringworm and jock itch.	TOPICAL Apply to affected area 2 x a day	Keep affected area clean and dry. Do not use on nails or scalp around mouth or eye's.
Benadryl (Diphenhydramine)	Temporarily relieves runny nose, itching of nose or throat, sneezing, itchy watery eyes due to allergies.	1- 25mg capsule every 4-6 hours as needed	May cause drowsiness
Multi-Vitamins	Dietary supplement	Oral 1 tablet daily	1 daily in morning
Cold & Flu medications Theara-flu CCP, Medi-phenyl	Nasal congestion, cold & flu symptoms.	Oral Follow instructions on box.	Stop medication if nervousness, dizzy or sleepless
Medikoff Drops	Cough, relief of minor throat irritation, sore throat and mouth pain, makes nasal passages feel better	1 an hour as needed	Stop if cough persists for more than 1 week or is accompanied by fever, rash or persistent headache
Metamucil	For relief of occasional constipation and restoring regularity.	1 rounded teaspoon in 8oz fluid up to 3 x a day.	Stop use if constipation persists beyond 7 days.
Epi-pen	Use for anaphylaxis or severe asthma attack	Subcutaneous injection	Advise base immediately
Hydrocortisone cream	For minor irritations, itching, fungus infections of the feet	TOPICAL Apply to affected area 2 x a day	Apply with clean hands or Q-tip
Ibuprofen	Pain reliever, fever reducer	1- 200mg tablet every 4-6 hours, If 1 tablet is ineffective then may use 2. Do not exceed 6 tablets in 24 hours	Contact med office if S/S persist for 24 hours
Acetaminophen (Tylenol)	Relives minor aches and pains and fever reducer	2 tablets every 4-6 hours.	Do not take more than 12 in 24 hours
Diamode	Controls symptoms of diarrhea	2 capsules after 1 st loose BM. 1 capsule after each subsequent BM	Do not exceed 4 capsules a day.
Loratadine (Claritin)	Temporary relief of allergy signs and symptoms	Oral 1 tablet daily	Do not take if you have a history of liver or kidney disease.