ACADEMY DISTRICT 20 HIGH TRAILS PERMISSION FORM

Team Name: __________________________ Middle School: ____

Student Name: ____

Destination: **High Trails**

Date of Trip: _________________________________ Mode of Transportation: **ASD20 Bus**

Departure Time: _______________________________ Departure Location: ____________________

Return Time: __________________________________ Return Location: ________________________

Cost of Trip per Student:

I understand that the School District is not responsible for insuring my student with regard to the student's participation in the activity. I am responsible for obtaining any medical, accident, or other insurance that I may deem appropriate. I understand, however, that the student and I retain any legal rights we may have for Personal Injury Protection Coverage, to the extent it may be available, resulting from a motor vehicle or bus accident. I understand that the School District and its employees may have certain legal protections and immunities from liability with respect to any property damage or personal injury that may occur during the activity. The School District and its employees have not waived these protections and immunities. I understand that the School District and its employees may also have certain legal obligations with respect to the activity. I understand that the student's participation is entirely voluntary and the school will provide alternatives for those students who cannot participate in the activity. **All District policies and procedures apply to the trip. Violation of the policies/procedures or failure to follow directives, safety rules, etc. could result in the student being sent home and/or disciplined.** I acknowledge that I have read and understand this High Trails Permission Form.

Signature of Parent or Legal Guardian: ____

Date: ___________________________________

Colorado Outdoor Education Center, Inc./High Trails Education Center ("COEC")

Release of Liability and Assumption of Risk ("Release") for participation in the COEC/Academy District 20 High Trails Program (the "Program")

PLEASE READ CAREFULLY. BY SIGNING BELOW, YOU ARE AGREEING ON BEHALF OF THE MINOR AND ON YOUR OWN BEHALF TO RELEASE COEC AND OTHER PARTIES RELATED TO IT FROM LIABILITY.

IN CONSIDERATION of the privilege of the Minor's participation in the Program, the undersigned individual states as follows:

ASSUMPTION OF RISK: COEC intends to make me aware, and I understand, that participation in the Program activities, including, but not limited to, mountain activities, hiking, rock scrambling, recreational activities, and outdoor education classes, exposes the participant to certain risks, hazards, and dangers, including, by way of example, the risk of personal injury (including the risk of permanent disability or death), accidents, or illnesses in remote places (without the immediate availability of medical facilities), and exposure to adverse weather conditions and wildlife (the "Risks"). The Program activities will be led by Academy District 20 staff and by COEC Staff. The Risks may be caused by the Minor's own actions or inactions, the actions of others, the conditions in which the Program takes place, or the negligence of the "Released Parties" named below. I also understand that outdoor and recreational activities require physical exertion and any participant should be in good physical health. If the Minor is not in good health, I realize this may create additional risk. ON BEHALF OF THE MINOR AND ME, I FULLY AND VOLUNTARILY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES incurred by the Minor and me as a result of the Minor's participation in the Program.

RELEASE -- MINOR'S RIGHTS: I HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE COEC, and any of its directors, agents, officers, volunteers and employees, and sponsors and vendors, and other participants in the Program (collectively, the "Released Parties"), and each of them, of and from, and do discharge and waive, any and all claims, demands, losses, damages, and liabilities that the Minor may have or sustain, including attorneys' fees and costs, with respect to any and all property damage, economic loss, medical expense, personal injury, and other expense, injury, or harm, and/or death arising directly or indirectly out of the Minor's participation in the Program, including without limitation any and all of those Risks described above, in accordance with Colorado Revised Statutes section 13-22-107. The foregoing sentence shall apply (without limitation) to all claims, demands, losses, damages, and liabilities, including but not limited to claims for negligence, but excepting claims for willful and wanton, reckless, or grossly negligent acts or omissions, as provided in Colorado Revised Statutes section 13-22-107 or by other applicable Colorado law.

RELEASE -- PARENTS'/GUARDIANS' RIGHTS: I HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE the Released Parties, and each of them, and do discharge and waive, any and all claims, demands, losses, damages, and liabilities that I as the parent/guardian of the Minor may have or sustain, including attorneys' fees and costs, with respect to any and all property damage, economic loss, medical expense, personal injury, and other expense, injury, or harm, and/or death arising directly or indirectly from the participation of the Minor in the Program, including without limitation any and all of those Risks described above. The foregoing sentence shall apply (without limitation) to all claims, demands, losses, damages, and liabilities, except as otherwise provided by applicable Colorado law. The covenants and undertakings of this Release are given for and shall be binding upon me and the Minor's, family, heirs, estate, next of kin, executors, administrators, legal representatives, beneficiaries, successors and assigns.

INDEMNIFICATION: I FURTHER AGREE TO INDEMNIFY, SAVE AND HOLD HARMLESS the Released Parties, and each of them, from and against any and all claims, demands, losses, damages, attorneys fees and costs, expenses, and liabilities made against or incurred by any of them, including those for indemnity, contribution, or otherwise, arising from the Minor's participation in the Program and the Risks, whether resulting from claims, actions, or lawsuits asserted by me or by another person against the Released Parties, except to the extent prohibited by applicable law.

MISCELLANEOUS: In the event of a dispute between the undersigned and any of the Released Parties, the exclusive venue and jurisdiction for any lawsuit arising out of such dispute shall be the state courts located in Teller County, Colorado, or the federal courts located in Colorado. If any provision of this document is determined to be invalid for any reason, such invalidity shall not affect the validity of any of the other provisions, which other provisions shall remain in full force and effect as if this document had been executed with the invalid provision eliminated. I understand and agree that this document is intended to be as broad and inclusive as permitted under applicable law and shall be governed by Colorado law.

BY SIGNING BELOW, EACH UNDERSIGNED PARENT/GUARDIAN OF THE MINOR PARTICIPANT ATTESTS AS FOLLOWS: I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND HAVE SIGNED IT FREELY AND VOLUNTARILY; I HAVE LEGAL RESPONSIBILITY OVER THE MINOR PARTICIPANT, AND, IF I AM THE SOLE PARENT/GUARDIAN SIGNING BELOW, MY SIGNATURE IS SUFFICIENT TO ENTER INTO THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK FOR AND ON BEHALF OF THE MINOR.

PROVIDE NAME OF MINOR: ____

{THIS IS A RELEASE} {THIS IS A RELEASE} {THIS IS A RELEASE}

Parent/Guardian's Signature | Printed Name | Date

{THIS IS A RELEASE} {THIS IS A RELEASE} {THIS IS A RELEASE}

Parent/Guardian's Signature | Printed Name | Date

{THIS IS A RELEASE} {THIS IS A RELEASE} {THIS IS A RELEASE}

Minor's Signature | Printed Name | Date

High Trails
outdoor education center

Student Name ____________________
School/Team ____________________
Session Date ____________________

EMERGENCY INFORMATION FORM

Required for ALL students at High Trails:

Completion of EMERGENCY INFORMATION FORM
Parent/Legal Guardian signature for AUTHORIZATION FOR EMERGENCY TREATMENT
Parent/Guardian signature PART A: AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

Complete PARTS B, C, and D if students will bring any over the counter or prescription medication to High Trails (pages 3 and 4).

Please fill in all blanks with relevant information or indicate Not/Applicable (N/A).

Student Name (last, first)____________________

Date of Birth ____________ Gender **M** **F**

Parent Name____________________ Home Phone____________

Parent Address____________________ Dad Work Phone____________ Dad Cell ____________

____________________ Mom Work Phone____________ Mom Cell ____________

Emergency Contact (if the above can't be reached) ____________________ Relationship ____________

Home Phone ____________ Cell Phone____________ Work Phone ____________

Health Concerns: This section must be filled out in entirety.

Does your child have any of the following health and/or diet concerns?

Communicable Disease? (yes/no) Explain if illness occurred in the last three weeks. ____________
Asthma? (yes/no) Explain ____________
Inhaler? (yes/no) What type? (rescue, preventative)____________
Drug Reactions? (yes/no) Is so, to what? ____________
Allergies? (yes/no) If so, to what? ____________
Epi-Pen? (yes/no) For what specific allergin? ____________
Diabetes? (yes/no) Explain ____________
Operations? (yes/no) Explain ____________
Dietary Restrictions? (yes/no) Explain ____________
Medical Condition? (yes/no) Explain ____________

Student's Doctor____________________ Doctor's Phone____________

Medical Insurance? (yes/no) Name of plan____________________ Policy/Group# ____________

AUTHORIZATION FOR EMERGENCY TREATMENT

In the event I cannot be reached in an emergency, I hereby give permission to the licensed medical provider selected by the Director of High Trails and the teacher/administrator in charge from my school to secure and administer treatment, including hospitalization, for the person named above. I understand that reasonable attempts will be made to notify me regarding any illness or accident requiring off-site treatment. I authorize High Trails staff and/or school personnel to transport my child to medical care.

____________________ ____________________ ____________

Parent/Legal Guardian Signature Print Name Date

High Trails
outdoor education center

Student Name ________________________
School/Team ________________________
Session Date ________________________

PART A: AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS

If your child develops a need for over-the-counter medications during his/her stay at High Trails, some medications are stocked in the High Trails Health Center. The High Trails nurse will assess a need and administer these medications for symptomatic relief.

The over-the-counter medications (or the generic equivalent) at the Health Center include:

Acetaminophen (Tylenol)
Acetaminophen/Caffeine/Pyrilamine Maleate (Midol)
Ibuprofen (Motrin/Advil)
Naproxen (Aleve)
Decongestants (Dimetapp/Sudafed)
Antihistamine (Benadryl/Claritin)
Antacid (Mylanta/Tums)
Insect repellent (containing DEET)
Cough drops (Throat lozenges)
Sunscreen

____ I ***give*** permission for the nurse at High Trails Outdoor Education Center to give my child, ________________________________, over-the-counter medications ***except for*** ___________________________________ to provide symptomatic relief of the condition.

____ I ***do not give*** permission for my child, ________________________________, to receive any over-the-counter medication.

____ ___________________________
Parent/Legal Guardian Signature Date

Student Name ______________________
School/Team ______________________
Session Date ______________________

Required for all students who bring prescription or over-the-counter medication to High Trails:
Parent/Legal Guardian Completion/Signature -- PART B
Parent/Legal Guardian Signature -- PART C
Health Care Provider Completion/Signature -- PART D

PART B: AUTHORIZATION FOR THE NURSE TO ADMINISTER MEDICATIONS BROUGHT TO HIGH TRAILS

If your student will **BRING** prescription, over-the-counter, homeopathic, and/or herbal medications to be taken while at High Trails, please fill out and sign below. **Medications cannot be given without this authorization. You must also complete PART C and the health provider PART D**.

The Parent/Legal Guardian of ________________________________, requests the nurse at High Trails give
Child's Name

medication(s) to my child, as directed by the health care provider.

______________________	______________________	____________
Print Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

Notes from home regarding medication administration:____
____
____
____

PART C: AUTHORIZATION FOR THE HEALTH CARE PROVIDER TO PROVIDE MEDICAL INFORMATION TO HIGH TRAILS

***Prescription medications** must have a signed health care provider authorization and must come in the original pharmacy container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, licensed health care provider's name, pharmacy name and phone number.

***Over-the-counter medication brought to High Trails** must have a signed health care provider's authorization and must be labeled with the child's name. Dosage must match the signed health care provider's authorization, and the medicine must be packaged in the original container. All over-the-counter medications require a health care provider's authorization including, but not be limited to: vitamins, allergy medication, cough drops, antacids, analgesics, etc.

By signing below, I give permission for my child's health care provider to share information about the administration of this medication with the High Trails' nurse or director.

______________________	______________________	____________
Print Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

High Trails
outdoor education center

Student Name ________________________
School/Team ________________________
Session Date ________________________

PART D : **AUTHORIZATION BY HEALTH CARE PROVIDER TO ADMINISTER MEDICATION AT HIGH TRAILS**

Child's Name: ____ Birthdate: _______________

Medication Example: Benadryl ***Dosage: 12.5 mg*** ***# of tablets: 2*** ***Total amount to be administered: 25 mg***
Frequency: Daily ***Time(s): Breakfast Lunch Dinner Bedtime***
Purpose of Medication: ______________________________ ***Report These Possible Side Effects:*** _________________________
Special Instructions & Notes: ____

Medication #1:_______________________ Dosage: ____________ # of tablets: ______ Total amount to be administered: ______
Frequency: __________________________ Time(s): **Breakfast Lunch Dinner Bedtime**
Purpose of Medication: ______________________________ Report These Possible Side Effects: __________________________
Special Instructions & Notes: ____

Medication #2:_______________________ Dosage: ____________ # of tablets: ______ Total amount to be administered: ______
Frequency: __________________________ Time(s): **Breakfast Lunch Dinner Bedtime**
Purpose of Medication: ______________________________ Report These Possible Side Effects: __________________________
Special Instructions & Notes: ____

Medication #3:_______________________ Dosage: ____________ # of tablets: ______ Total amount to be administered: ______
Frequency: __________________________ Time(s): **Breakfast Lunch Dinner Bedtime**
Purpose of Medication: ______________________________ Report These Possible Side Effects: __________________________
Special Instructions & Notes: ____

Medication #4:_______________________ Dosage: ____________ # of tablets: ______ Total amount to be administered: ______
Frequency: __________________________ Time(s): **Breakfast Lunch Dinner Bedtime**
Purpose of Medication: ______________________________ Report These Possible Side Effects: __________________________
Special Instructions & Notes: ____
Use additional form if necessary.

Signature of Health Care Provider with Prescriptive Authority *Phone Number* *Date*

Printed name of Health Care Provider with Prescriptive Authority

This form complies with regulations of the State of Colorado for medication administration.