



Dear Parent,

Thank you again for your interest in the licensed therapeutic program for adolescents offered by Trails Carolina. In addition to the Trails Carolina application and to ensure a seamless transition for your child we require the following information, along with the Enrollment Agreement, and all other required consents and authorizations ***at least 24 hours prior*** to admission:

- 1. A copy of your child's immunization records***
- 2. A copy (front and back) of your child's insurance card***
- 3. A hard copy of your child's prescriptions to match their medication.***

(There is a \$3 fee for each prescription filled for bubble packing.)

Please fax all information to 888-314-3010 or e-mail it to admissions@trails-carolina.com.

Thank you for your assistance with this process. If we can answer any questions or concerns that you may have please contact us at 888-387-2457.

Sincerely,

TRAILS CAROLINA ENROLLMENT AGREEMENT

(Including Assumption of Risks, Release and Indemnity)

This Enrollment Agreement (“Agreement”) is entered into by and between Trails Carolina, LLC, a North Carolina limited liability company (hereinafter “Trails”) and _____ parent(s)/guardian(s) (collectively the “Sponsor”) of _____ (the “Student”). Trails and the Sponsor are sometimes referred to individually as a “Party” and collectively as the “Parties”.

***In consideration of the mutual promises set forth in this Agreement,
the Parties mutually agree as follows:***

1. SPONSOR’S REPRESENTATIONS. Sponsor acknowledges and agrees that Sponsor is the legal parent(s) and/or guardian(s) having legal custody of Student, and that Sponsor desires to and does hereby contract with Trails for the purpose of securing Student’s placement in the Trails’ Wilderness Therapy Program (the “Program”) according to the terms and conditions of this Agreement. In entering into and performing under this Agreement, Trails is relying on all representations and promises of the Sponsor contained or expressed in this Agreement and other documents and information provided by Sponsor to Trails, and Sponsor expressly warrants the truth and accuracy of all such documents and information.

2. ELIGIBILITY AND ENROLLMENT OF THE STUDENT. Sponsor must submit to Trails the following: a completed and executed copy of this Agreement and the Payment Agreement; completed and executed copies of all required consents, authorizations and information requests; and the initial payment required by the Payment Agreement (the “Required Submissions”). Upon Trails’ receipt of the Required Submissions, Trails will evaluate the Required Submissions. Upon Trails’ execution of this Agreement and Student’s physical arrival at Trails, Trails shall conditionally accept the Student for enrollment in the Program subject to the terms and conditions of this Agreement. Sponsor acknowledges and agrees that Trails’ conditional acceptance of the Student is subject to the personal evaluation and screening process conducted by Trails prior to completion of the Assessment phase of the Program. If the Student satisfies Trails’ screening criteria, Trails shall enroll the Student and, except as otherwise provided herein, permit the Student to participate in the Program. If the Student fails to satisfy any of Trails’ screening criteria at the sole discretion of Trails, the Student will not be enrolled in the Program and will be discharged. Trails retains the right to discharge the Student at any time for medical or clinical reasons, or as otherwise allowed under this Agreement.

3. TERM OF AGREEMENT/CUSTODY. Except as otherwise provided, the term of this Agreement shall be from the date it is executed by Trails until the earlier of the date that the Student is (a) returned to Sponsor; (b) returned to custody of a court of proper jurisdiction or (c) voluntarily leaves the Program after the Student’s eighteenth birthday. Sponsor agrees to make all arrangements necessary for Student to travel to and from Trails and is responsible for all costs associated with such transportation. On the date that the Student physically arrives at Trails, which is expected to be _____ (the “Arrival Date”), Sponsor shall transfer temporary custody of the Student to Trails for the term of the Agreement unless the Student (a) has otherwise been placed in the custody of Trails by a court of proper jurisdiction or (b) reaches his or her eighteenth birthday and voluntarily consents in writing to remain in the Program

4. FEES, COSTS AND PAYMENT TERMS. This Section shall survive termination of this Agreement.

A. Tuition and Enrollment Fees. The tuition fee is **\$450.00 per day** (the “Tuition Fee”). The Tuition Fee is charged for any day in which the Student is enrolled in the Program and/or in the custody of Trails. A partial day is billed for a full day. **The enrollment fee is \$2,000.00** (the “Enrollment Fee”).

B. Incidental Fees. There are additional incidental costs and expenses to participate in the Program, including the initial physical cost, initial evaluations, medication costs, outfitting costs, escorting fees and transportation costs for off-site visits, and all medical, dental, hospital, and related expenses incurred by or for the Student (the “Incidental Costs”).

C. Schedule and Method of Payment for Program Fees.

(1) Prior to the conditional acceptance of a Student, the Sponsor must pay a **minimum initial payment** of \$_____ (which includes the Tuition Fee for the first ___ days of the Program and the Enrollment Fee) (the “Initial Payment”) and may prepay additional days of Tuition Fees (the “Initial Prepayment”). The Initial Payment may be paid by check, accepted credit card or wire transfer and must be accompanied by the Fee Payment Agreement.

(2) After the conditional acceptance of the Student, Sponsor agrees to pay all Incidental Costs. Prior to the conditional acceptance of the Student, Sponsor must provide a valid credit card (VISA, Mastercard or American Express) with available credit at the time of admission for the payment of any Incidental Costs.

(3) If the Student remains in the Program after the numbers of days that have been prepaid by the Initial Payment, the Tuition Fee of \$450.00 per day will apply to each additional day of participation in the Program (the “Additional Tuition Fees”). Sponsor agrees to pay any Additional Tuition Fees in two week increments due on the first day of each two week period. Sponsor acknowledges that failure to pay the Additional Tuition Fees could result in the discharge of the Student. Prior to the conditional acceptance of the Student, Sponsor must provide a valid credit card (VISA, Mastercard or American Express) with available credit at the time of admission for the payment of any Additional Tuition Fees.

(4) With the exception of the discharge summary, no Student files or records will be released until all outstanding Tuition Fees, Enrollment Fees, Incidental Costs and any other amounts due under this Agreement are paid in full.

D. Cancellation/ Early Withdrawal. The Enrollment Fee is not refundable. If Trails receives a written cancellation more than **seven (7) days prior** to the Arrival Date, the Sponsor will be entitled to a full refund of the Initial Payment (less the Enrollment Fee) and any Initial Prepayments. If Trails receives a written cancellation seven (7) days or less prior to the Arrival Date, the Sponsor will be entitled to a 50% refund of the Initial Payment (less the Enrollment Fee) and a full refund of any Initial Prepayments. After the Arrival Date, the Initial Payment is not refundable (unless the Student withdraws before the 28th day with the recommendations of the Program Director, in which case the Tuition Fees for the unused days will be refunded to the Sponsor) but any unused Initial Prepayments are refundable. Any Additional Tuition Fees are non-refundable. Any non-refundable, unused amounts retained by Trails may, if deemed appropriate by Trails, be used as credit against any future enrollment of the Student.

5. SUBCONTRACTING. Sponsor agrees and consents to Trails subcontracting certain services to be rendered under this Agreement to persons or entities deemed by Trails to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both Parties. Trails 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 Trails. 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. This section shall survive the termination of this Agreement.

6. NURSING CARE. Trails 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 Sponsor. Trails 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. *This section shall survive the termination of this Agreement.*

7. 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, mountain biking, 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 Program 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 Program with knowledge of the dangers involved and agree to accept any and all risks.

In consideration for being permitted to participate in the Program, Sponsor agrees to not sue, to assume all risks, and to release, hold harmless and indemnify Trails 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, (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.

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 Program, 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. 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 Program. 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.

Sponsor represents that Student is physically capable of participating in the Program, 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, Sponsor represents that Student's medical care provider knows of and has approved Student's participation in the Program. 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 Program.

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 Student's participation in the Program.

Sponsor acknowledges and agrees that Trails 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. This section shall survive the termination of this Agreement.

8. STUDENT RUNAWAY ATTEMPTS. In the event the Student runs away from the Program, Trails will make every reasonable effort to find the Student and return the Student to the Program or to the Sponsor. 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 Trails arrive, at which time Trails 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. Sponsor hereby releases, holds harmless and indemnifies Trails from any and all claims, damages, and liabilities arising out of or resulting from Student running away while in Trails custody and/or participating in the Program, including, but not limited to, claims of personal injury or property damages or loss incurred by the Student, the Sponsor or any other third parties. An accounting of the expenses incurred by Trails 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. This section shall survive the termination of this Agreement.

9. PERSONAL INJURY AND DAMAGE TO PROPERTY. Sponsor agrees to accept full financial and legal responsibility for (1) the repair or replacement of any property damaged, defaced, or destroyed by the Student, whether owned, leased, or controlled by Trails or any third party, and (2) any personal injury to any Trails personnel, other students or third parties caused, in whole or in part, by the Student; and to promptly reimburse Trails for any costs and expenses, including legal fees, it may incur in connection therewith, and to pay any of the above mentioned damages within seven (7) days of the Sponsor's receipt of said accounting. This section shall survive the termination of this Agreement.

10. AUTHORIZATION FOR MEDICAL CARE AND RECORDS. In the event of an accident, injury, illness, or other medical necessity, Sponsor hereby authorizes Trails to: (a) provide emergency first aid to the Student in the field and en route 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 Trails 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 Trails to arrange for a physical examination (including a drug screen urine/blood test, at Trails' option) and any psychological assessments of the Student deemed necessary by Trails prior to the Student beginning the Program. Sponsor also authorizes any and all medical doctors, psychiatrists, psychologists, counselors, therapists, hospitals, clinics and treatment centers that have treated or counselled the Student, and whose names Sponsor shall provide to Trails, to release all information regarding the Student's medical and/or psychological history, diagnoses and treatments to Trails upon request. Trails 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. This section shall survive the termination of this Agreement.

11. AUTHORIZATION FOR SEARCH AND SEIZURE. Sponsor hereby authorizes Trails personnel to search the person and personal effects of the Student at any time, including a "strip search." In connection with such search, Trails 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. Trails is further authorized to confiscate any and all items deemed by Trails to be contraband or counterproductive to the Student's successful completion of the Program. The disposition of all items confiscated by Trails shall be left to the sole discretion of Trails.

12. AUTHORIZATION FOR RESTRAINT. Sponsor hereby authorizes Trails personnel to physically restrain, control and detain the Student by the exercise of necessary restraints when deemed necessary by Trails, for purposes including but not limited to escorting the Student to and from field locations, 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.

13. RESEARCH AUTHORIZATION. Sponsor hereby authorizes Trails 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. This section shall survive the termination of this Agreement.

14. EARLY TERMINATION BY TRAILS/LIQUIDATED DAMAGES. Trails reserves the right to terminate this Agreement at any time due to: (i) failure of Sponsor to pay any amounts due under Section 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 Trails deems it necessary for the protection of the Student, any other student(s) or the integrity of the Trails Program. In the event that Trails elects to terminate the Student pursuant to the terms of this paragraph, Sponsor understands and agrees that Sponsor forfeits all amounts paid to Trails under Section 4. The forfeiture reflects the recognition that certain costs associated with enrolling the Student in the Program 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 is a reasonable estimate of the losses (i.e., Liquidated Damages) the Program incurs with the early termination of Student.

15. SPONSOR EDUCATION PROGRAM AND COOPERATION. Sponsor agrees to attend the seminar for parents and guardians of the students conducted by Trails during the Program, and to give Sponsor's full cooperation to Trails 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 Trails, and to fill out and return to Trails any interactive educational materials, while the Student is in the Program.

16. AUTHORIZATION OF PHOTOGRAPHS. Sponsor agrees that photographs or other images may be taken of Student for Trails' confidential records and for the purpose of sending photographs to Sponsor.

17. 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.

18. EMANCIPATION. Sponsor warrants that the Student is a minor, both by age and as a matter of law, that the Student is not 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.

19. 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 as soon as practicable.

20. 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 Trails for all reasonable attorneys' fees and costs incurred by Trails in connection with those matters concerning which Sponsor has agreed to pay or indemnify Trails herein. This section shall survive the termination of this Agreement.

21. NOTICES. Any and all notices, payments, reports and other correspondence required here-under 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).

Trails Carolina, LLC
500 Winding Gap Road
Lake Toxaway, NC 28747

SPONSOR'S NAME _____
ADDRESS _____
CITY, STATE, ZIP _____

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.

23. 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.

24. 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.

25. GOVERNING LAW/VENUE. Should a parent, legal guardian, or a child have a grievance, they should be encouraged to speak directly with the Primary Therapist or Admissions Director to resolve the grievance. Any issues that a client believes have not been satisfactorily addressed can be directed to the Executive Director of Trails. 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 North Carolina; and the Parties consent and submit to the exclusive jurisdiction and venue of the North Carolina Courts in Transylvania County, North Carolina, and any qualified (American Arbitration Association-approved) arbitration service in the State of North Carolina to enforce this Agreement. The Parties acknowledge that this agreement constitutes a business transaction within the State of North Carolina. This section shall survive the termination of this Agreement.

26. 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. This section shall survive the termination of this Agreement.

27. 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.

28. 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, the Payment Agreement and the Related Authorizations and Consents 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, Trails 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 Trails set forth herein. This section shall survive the termination of this Agreement.

29. BINDING EFFECT. This Agreement may not be assigned by the Sponsor. Notwithstanding the foregoing, this Agreement shall be binding upon and inure to the benefit of the Parties hereto, their heirs, personal representatives, successors and assigns. This section shall survive the termination of this Agreement.

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

Sponsor (father/guardian) Date

Sponsor (mother/guardian) Date

Accepted by Trails Carolina, LLC

Name Title Date



PAYMENT AGREEMENT

Student's Name: _____

I understand that the tuition fee to participate in the Trails Carolina Program is **\$450 per day** and that there is a **\$2,000.00 enrollment fee**. The average length of stay at TRAILS is **60 to 90 days** and based on the individual needs of each student. There is a minimum initial payment of \$_____ which covers the tuition fee for the first ___ days of the program and the enrollment fee. I agree to prepay for _____ days (**a minimum of 28**) at a rate of \$450.00 per day PLUS an enrollment fee of \$2000.00.

My total initial payment will be $\$450 \times \frac{\text{Total Days}}{\text{Total Days}} + \$2,000 = \text{_____}$ (a min. of \$_____)

Please indicate your method of payment for the initial payment:

Credit Card **Circle:** Visa MasterCard Amex

Card # _____

Expiration Date _____ CCV _____

Signature _____ Date _____

Billing Address _____

Check payable to Trails Carolina, LLC

Send payments to:

Trails Carolina LLC, 500 Winding Gap Road, Lake Toxaway, NC 28747

Wire Transfer

Please call 888-387-2457 in order to receive specific wiring instructions

I further understand that there are additional incidental costs and expenses to participate in the Program that will be billed to the credit card provided below. I further understand that if our child remains enrolled in the Program beyond the number of days that have been prepaid, there is a tuition fee of \$450.00 per each additional day of participation that will be billed to the credit card provided below in two week increments on the first day of each two week period.

Even if you are paying the initial payment by means other than a credit card, you must provide a credit card for payment of additional tuition fees and incidental expenses.

Use the above Credit Card Use this card for incidental costs

Card # _____

Expiration Date _____ CCV _____

Signature _____ Date _____

Billing Address _____

A fully completed and executed copy of this Payment Agreement and the initial payment must be received prior to your child's enrollment.

Parent/Guardian _____ Date _____

Parent/Guardian _____ Date _____



CONSENT FOR RELEASE OF INFORMATION

(Please duplicate if needed)

Student Name _____ Parent/Guardian _____

Student SS# _____ Parent Phone # _____

Date of Birth _____ Date of Admission _____

Father Signature _____ Mother Signature _____

I/we authorize Trails to release any and all information to the referral source listed on this application. I/We authorize the below named educational consultants, professionals, schools, and/or institutions to release and receive all information concerning the above named student to and from Trails.

Information should include as much of the following as would be helpful in providing additional assessment and continuation care: medical/treatment history, psychological evaluations, discharge summaries, progress case notes and/or academic records and transcripts.

Please include Referring Professional (Educational Consultant, Therapist, School Counselor, etc.) and anyone else that will be of value for the staff to be in contact with to assist in the therapeutic and academic process for your child.

This authorization will remain in effect for one (1) year from the date of enrollment stated above.

Name: _____	Phone: _____
Title: _____	E-Mail: _____

Name: _____	Phone: _____
Title: _____	E-Mail: _____

Name: _____	Phone: _____
Title: _____	E-Mail: _____

Name: _____	Phone: _____
Title: _____	E-Mail: _____



PSYCHOLOGICAL AND PSYCHOEDUCATIONAL TESTING

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

A comprehensive battery of psychological testing is a standard at Trails Carolina. Trails Carolina 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 consult with your child's therapist at Trails Carolina to assist in developing the most appropriate treatment plan while at Trails Carolina and in preparation for transition and aftercare.

Consent to Administer Psychological Testing

I hereby agree to psychological testing for my minor child named below. I also agree to allow the psychologists and/or graduate students who are under the psychologists' supervision to have access to my child's records at Trails Carolina. Trails Carolina has my permission to release information about my child to CReATE. I understand that CReATE will keep all information confidential and will not share the information with anyone else, or any other agency, without my written consent. I understand that the psychologist will consult with my child's Trails Carolina therapist and/or Trails Carolina staff to enhance the treatment of my child named below. I agree to allow the psychologist to contact only those I have listed on the Informed Consent on record at Trails Carolina. I understand that the psychologist will follow all Confidentiality and Privacy Policies of Trails Carolina.

Yes, I would like to have my child evaluated.

Fee: \$2,125 (In addition to the program tuition)

Name of Child: _____

Name of Parent/Guardian: _____ Relationship to Minor _____

Payment via Credit Card (Circle One: *Visa MasterCard Amex*) ***Use card on Payment Agreement***
Card Number _____ Expiration Date _____ CCV _____
Billing Address _____

Payment via Check (***Payable to Trails Carolina, LLC, 500 Winding Gap Road, Lake Toxaway, NC 28747***)

Payment via Wire Transfer (***Call 888-387-2457***)

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

Signature of Parent/Guardian

Date

The Process:

After your child or adolescent enters Trails Carolina, his/her testing date will be scheduled for the second week of enrollment. This gives your child sufficient time to acclimate to the program and to allow for initial contact with your child's therapist. The psychologist will then come on-site to Trails Carolina and review your child's file, including the application that you completed as well as any previous testing data, medical records, and/or Trails Carolina records. Your child will complete testing forms in the week leading up to the testing day. On the day of testing, the psychologist will conduct all testing in a climate-controlled room that mimics an office setting. In the days following testing, the psychologist will send testing forms for you (the parent) to complete. Then, a phone conference will be scheduled with you (approximately 90-120 minutes) during which time the psychologist will gather more detailed information from you about your child as well as give you verbal feedback about the testing results and recommendations for treatment and intervention. You will be given opportunity to ask questions as well. Following the phone call, the psychologist will compile all results and historical data into a comprehensive written report that can be shared with future treatment providers. In general, the verbal feedback occurs approximately 4 working days after the testing day and the written report is completed within approximately 2 weeks of the testing date.



AUTHORIZATION AND CONSENT FOR ELECTRONIC COMMUNICATION

I/we authorize Trails Carolina, LLC to transmit personal communications from my child to me by email or facsimile.

Please email or fax all student communications to me at the following email address(s) and/or facsimile numbers(s):

EMAIL ADDRESS(S): _____

FAX NUMBER(S) _____

TRANSMISSION ERRORS

I/we understand that errors sometimes occur in the transmission of personal communications between children and parents. I/We release Trails Carolina, LLC from any and all liability for errors in the transmission of personal communications between my child and myself and any other parties. I/we agree to keep confidential the nature of any communication that I/we may receive in error and to contact Trails Carolina immediately at 828-885-5920 or by email at office@trails-carolina.com.

Mother (Please Print) _____ Date _____

Mother Signature _____

Father (Please Print) _____ Date _____

Father Signature _____



TRAILS STUDENT MEDICAL FACE SHEET

Should you require more room please use the back of this form

Student Full Name: _____ DOB: _____

Student Social Security Number: _____

.....
Primary Parent Full Name: _____ SS# _____

Full Address: _____
street city state zip

Phone Numbers: _____
Home cell

.....
Other Parent Full Name: _____ SS# _____

Full Address: _____
street city state zip

Phone Numbers: _____
Home cell

.....
Student's Current Medications:

Student's Previous Medical History

Allergies (medications, food, etc...): _____

Previous Major Injuries or Surgeries (include dates:) _____

Limitations/ Restrictions (Epi-Pens, Inhalers, etc...) _____

Last Medical Visit: _____ Physician's Name: _____

Last Dental Exam: _____ Dentist's Name: _____

Other Significant Information: _____



PRESCRIPTION AND OVER THE COUNTER MEDICATIONS

Dear Parents,

Please carefully read this note regarding prescription and over-the-counter medications. Following these instructions will help prevent interruptions in your child's medication regimen. Any questions or concerns can be directed to the Admissions Director or Field Medic.

- Please make certain your student arrives with at least a 30-day supply of all prescription and non-prescription medication. If a 30-day supply is unavailable, please send or bring a written prescription.
- All medications (including vitamins and supplements) must be accompanied with a written prescription or medical authorization from the prescribing physician. Please be sure the doctor's authorization includes the child's name, medication, dosage, directions of administration, date, and the physician's signature.
- If your child requires special attention for orthodontics, dietary needs, eye glasses, etc. Please communicate what will be necessary to maintain the care of these items while your student is at TRAILS.
- By law, all medications must be administered as the prescription on the bottle reads. If you administer your child's medication differently, please include a note from the prescribing physician detailing any adjustment.
- If there is any additional information regarding past injuries or illnesses your child may have experienced that may be beneficial in maintaining your child's health, please discuss it with the Admissions Director or Field Medic.
- Please ensure that we have both a legible copy of your child's insurance card as well as prescription coverage card. • Also, please include your child's most recent immunization record. As a safety precaution, if your child has not received a tetanus booster within the last 5 years, they will receive one upon admittance.

Thank you,

Trails Carolina Field Medical Team

Clinically Driven... Family Focused...
SAFETY PROVEN!



INDIVIDUALIZED STANDING ORDERS FOR PRESCRIPTION AND OVER THE COUNTER MEDICATIONS

Student: _____ Date of Birth: _____ Age: _____ Sex: _____

Weight: _____ Height: _____ Shoe Size: _____ Waist: _____ Shirt Size: _____

Please list any MEDICATION (including vitamins, supplements, etc.) your child is **CURRENTLY** taking and bringing to Trails. Please use an additional sheet of paper if needed. Indicate "NONE" if your child is not currently taking any medication.

All medications MUST include a written prescription and be in the original container. All medications (including vitamins and supplements) must include a valid prescription or they will not be dispensed.

If you have been given verbal directions to change dosage or time of administration, we must receive signed and dated instructions from the prescribing doctor. These can be faxed to 828-885-5922, or e-mailed to office@trailscarolina.com.

Medication	Reason for Taking/ Indications	Side Effects/ Reactions	Time Administered	Dosage and Route as per Physician	Comments

- Yes, my child will be bringing a retainer including a protective plastic case for storage.
- Yes, my child will be bringing prescription eyeglasses including a protective case for storage. Please, no contact lenses.
- Yes, my child has a history of refusing to take medication. Please list any side effects/reactions: _____
- Yes, my child is a vegetarian.
- Yes, my child has special dietary needs. Please specify: _____

Please list any allergies, special medical conditions or dietary concerns that effect you child including, but not limited to: reactions to poison ivy, peanuts, shellfish, latex, etc.

Allergy/Condition	Reaction	History

Parent and Student Physician:

(Individualized Standing Orders for Prescription and Over the Counter Medications cont.)

For each medication listed below, please circle “Yes” or “No” to indicate whether or not you give Trails’ health care staff permission to administer the medication to the student. These medications are stocked in our health care center, so you do not need to send them to Trails. The student’s physician provides the order and the parent provides the consent.

Name of Medication	Route	Dosage	Schedule & Indications	Student’s Physician	Parent/ Guardian Consent
Diphenhydramine Hydrochloride (Benadryl)	PO:25mg capsule	Per label instructions by age & weight	Q 4-6 hours as needed for mild to moderate Allergic Reactions (insect bites, hives or rashes)	Yes No	Yes No
Epinephrine	IM: 0.3mg Auto-Injector “EpiPen”	Per label instructions by age & weight	Q repeat as soon as 5 minutes if needed for severe allergic reactions/asthma	Yes No	Yes No
Ibuprofen (Advil Motrin)	PO: 200mg tablet	Per label instructions by age & weight	Q 4-6 hours for pain or fever > 100.5°F	Yes No	Yes No
Acetaminophen (Tylenol)	PO: 325mg tablet	Per label instructions by age & weight	Q 4-6 hours for pain or fever > 100.5°F	Yes No	Yes No
Bismuth Subsalicylate (Pepto Bismol)	PO: 262mg chewable tablet	Per label instructions by age & weight	Q 30 minutes-hour as needed for diarrhea, nausea, heartburn (no >8 doses/24 hours)	Yes No	Yes No
Phenylephrine HCL Nasal Decongestant	PO: 10mg tablet	Per label instructions by age & weight	Q 4 hours as needed for congestion, sinusitis, head cold, ear blockage (no > 6 doses/24 hours)	Yes No	Yes No
Multi-Symptom Cold Relief	PO: 325mg acetaminophen - 15mg dextromethorphan hydrobromide - 200mg guaifenesin - 5mg phenylephrine hydrochloride	Per label instructions by age & weight	Q 6-8 hours as needed for symptoms of the common cold (no > 8 doses/24 hours)	Yes No	Yes No
Throat Lozenge	PO: 7.6mg menthol per lozenge	Per label instructions by age & weight	Q no >1 per hour not to exceed 8 doses/24 hours as needed for cough, sore throat, minor throat irritation	Yes No	Yes No
Daily Multivitamin	PO:	Per label instructions by age & weight	Q one tablet daily with food	Yes No	Yes No
Cranberry Softgel	PO: 100mg vitamin C 3 IU Vitamin E 140mg Cranberry Extract Powder	Per label instructions by age & weight no >6 doses daily	Q one softgel daily to promote urinary health, no >6 doses daily	Yes No	Yes No

Our Health Care staff is not authorized to administer over the counter medication and prescription medications without the student’s Health Care Provider’s order and consent of the parent/guardian, as indicated on both sides of this page and as signed below.

Student Name: _____ Physician Name: _____

Parent/Guardian Name: _____ Address: _____

Parent/Guardian Signature _____ Date: _____ Phone: _____

Date: _____ Signature: _____



CONSENT FOR MEDICAL EXAMINATION AND TREATMENT

I/we give permission to Trails Carolina to provide my child with an enrollment physical, and to seek medical, hospital, dental, or psychiatric attention in the event of injury or illness, and to provide emergency first aid as needed, in the field until such care can be reached or given. I/we understand that all costs of medical care and medication needed while the student is enrolled at TRAILS are my/our responsibility. I/we authorize any professionals who have provided treatment to our student to release information to TRAILS. I/we are obligated to provide medical insurance for student and must provide proof of medical insurance prior to the start of any program.

We require that you please submit a credit card number to cover the initial physical, medication(s), and any other medical expenses. You will be issued a receipt that you can then turn into your insurance company.

I authorize Trails Carolina to use my credit card for any medical services that are incurred for the duration of the program. I understand a Trails representative will notify me of any charges billed to my credit card.

*Payment via Credit Card (Circle One: Visa MasterCard) *The pharmacy and doctor's office do NOT accept AMEX.

Card Number _____ Expiration Date _____ CCV _____

Billing Address _____

Authorized Signature: _____ Date: _____

We will do our best to process the prescription(s) through your insurance, but please understand that some insurance companies do not contract with all pharmacies. You are fully liable for any balance not paid by your insurance. The pharmacy that Trails uses will not process prescriptions through your insurance without a copy of both sides of your insurance card.

Prescription Drug Coverage Information

Student Name (please print) _____ Date of Birth _____

Student's Social Security # _____ Relationship to Subscriber _____

Name of Subscriber _____ Subscriber's Date of Birth _____

Name of Ins. Carrier _____ Phone Number () _____

Address _____ City _____ State _____ Zip _____

Group # _____ Subscriber ID # _____ BIN # _____ PCN _____

VERY IMPORTANT to complete this section:

Father's Name _____ DOB _____ Mother's Name _____ DOB _____

Address _____ Address _____

Father's Social Security Number _____ Mother's Social Security Number _____

Father's Phone _____ Mother's Phone _____



PHYSICAL EXAMINATION

(To be completed by your physician)

Any student arriving at Trails without a physical will automatically be given one at the expense of the parent(s). Exam must be current within 30 days of beginning the course.

Student Name: _____

Dear Doctor:

The above-stated individual is going to participate in an outdoor living program. He/She may on occasion hike up to 8 miles per day (typical is 2-6 miles a day) in sometimes very hot or very cold weather conditions at elevations of 2,000 to 5,000 feet. In addition, the student's will be participating in horseback riding and may participate in canoeing, and riding bicycles on trails. The student's diet will consist primarily of lentils, rice, whole wheat flour, rolled oats, powdered milk, raisins, granola, sunflower seeds, peanut butter, dried fruit, potatoes, carrots, onions and other similar food basics. The participant will NOT be involved in technical mountain climbing, or rafting. He/She may be living at a base camp site and camping overnight in the temperate woodland terrain surrounding the facility. We would appreciate your candid appraisal of this applicant's health. If you are aware of any health reason why this applicant should not be involved in an outdoor program such as this, please specify.

The applicant should not be considered for this program if any of the following conditions exist: obesity to the extent of interfering with hiking, epilepsy (unless specially cleared with the program well in advance of the trip), diabetes or history of hypoglycemia (this is an absolute contra-indication), arthritis which might be aggravated by extensive exercise, or recurrent intense emotional states (hypertension, "nervous breakdown," chronic tranquilizer use, etc.).

Height: _____ Weight: _____ Lower Extremities: _____ Eyes: _____ Ears: _____

Back: _____ Lungs: _____ Heart: _____ Throat: _____

Nervous System: _____ Hernia: _____ Abdomen: _____ Blood Pressure: _____

Edema: _____ Pregnancy Test: _____

Exercise Tolerance Test: _____ Resting Pulse _____ Following 2 minute rest _____

Date of last tetanus (must be within 5 years.) _____

How long have you known this applicant? _____

Summary of positive findings: _____

General Appraisal

_____ Approval -- I find no defects which I consider incompatible with the activities described above.

_____ Disapproval -- This applicant has physical defects which, in my opinion, clearly constitute unacceptable hazards to his/her health and safety in the activities described above.

Recommendations and/or restrictions (if none, please specify): _____

Date: _____ Print physician name: _____ Address: _____

Signature: _____ Phone: _____

Note to the Examining Physician: If you have any questions concerning unusual physical or medical problems for attendance at this program .at this program, feel free to discuss it with us at the above number.



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.

Use and Disclosure of Health Information

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

Student Name: _____

Persons/Organizations authorized to use or disclose the information: *Trails Carolina*

Persons/Organizations authorized to receive the information: *Please See Consent for Release of Information*

Purpose of requested use or disclosure: *Medical Care and Treatment Planning*

This Authorization applies to the following information

✓ 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

This Authorization expires: *Upon Graduation*

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:*

**Trails Carolina. LLC
500 Winding Gap Road
Lake Toxaway, NC 28747**

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. 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, North Carolina 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

Signatures

Signature Date Time AM/PM
(patient/representative/spouse/financially responsible party)

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

Trails Witness Date Time AM/PM
(Can be signed by staff upon receipt)

(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. North Carolina law prohibits recipients of your health information from redisclosing 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 HIPAA, 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 HIPAA 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.

AGREEMENT AND CONSENT FORM
YMCA Camp Greenville

LAST NAME: _____
FIRST NAMES and AGES: _____
EVENT NAME and DATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
EMAIL ADDRESS: _____
PHONE: HOME _____ CELL _____ OFFICE _____

If your children are under 18 years old, please complete the following for your children to participate in this experience.

I, _____, give permission for my children, _____, to
Parent/guardian's name Children's names

participate in the activities at YMCA Camp Greenville in Cedar Mountain, North Carolina

on _____. I also
Dates of outing

Parent/Guardian's Signature: _____ Date: _____

The following information must be completed for anyone visiting YMCA Camp Greenville.

PHOTO RELEASE

I give my permission for any photos or videos taken of my family or me during the outing at YMCA Camp Greenville to be used for the public relations program.

MAILING LIST

I give my permission for YMCA Camp Greenville to add me to their mailing list.

LIABILITY

I hereby release YMCA Camp Greenville and the Greater Greenville YMCA and their employees, volunteers, and chaperones, from any financial or legal responsibility that may result from this outing. To insure prompt attention in case of serious accident or illness, I hereby authorize the persons responsible to incur expense deemed necessary and agree to pay for the same, if they are not covered by a school/agency accident and sickness policy. Should the need arise; I give permission to the YMCA Camp Greenville to take me to a doctor or hospital for medical treatment. I also authorize an agency chaperone to execute any or all documents in my behalf, including necessary releases, which might be required by a medical facility to perform emergency care.

MEDICAL AUTHORIZATION AND RELEASE

Should I sustain or incur an accident or illness while attending YMCA Camp Greenville, I hereby authorize an agency official to execute any and all documents in my behalf, including necessary releases, which my be required by a medical facility to perform emergency care.

Signature: _____ Date: _____

Dear Parent/Guardian,

TRAILS Carolina has partnered with Park City Independent online school to provide you with options regarding your student’s educational credits earned for his/her time at TRAILS. While enrolled, all students receive formal instruction in English, Earth science, and health/P.E. These classes are designed to enhance students’ overall understanding of their time at TRAILS and to keep their minds conditioned to return to school after completion of the program.



Option 1:

Students receive an official transcript from Park City Independent. Park City Independent is accredited through the Northwest Accreditation Commission (NWAC) and as such has nationally recognized accreditation. This is the same accreditation awarded to public schools, and is fully recognized by high schools and colleges across the country.

If a student is enrolled at TRAILS for a minimum of 50 days, s/he has the opportunity to earn three credits through Park City Independent in the following courses that officially recognize the experience of TRAILS Carolina:

Physical Education	1.0 credits
Outdoor Living Skills	0.5 credits
Environmental Science	0.5 credits
Interpersonal Communications	0.5 credits
Personal Writing	0.5 credits

Students will earn these credits for their participation in, and completion of the program; no additional work will be required of them. We are able to offer these nationally recognized credits for a minimal cost of \$250 per student. This is not a recurring cost or a per credit cost. \$250 covers the cost of all three credits.

Option 2:

Students receive an unofficial transcript issued by TRAILS Carolina that recognizes work completed in the following subjects:

Physical Education	1.0 credits
Earth Science	0.5 credits
English	0.5 credits

It is important to note that TRAILS Carolina is not an accredited secondary school; therefore, we’ve found that our credits are limitedly accepted by schools.

As parent/guardian of _____, I elect the following academic credit option for my student.

- Option 1: (3) Credits-nationally accredited (\$250)
- Option 2: (2) Credits-unaccredited (\$0)

Address for Transcripts:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Credit Card Authorization: _____