Adirondack
Leadership Expeditions

In addition to the Adirondack Leadership Expeditions application, we require the following information along with the remainder of this paperwork **at least 24 hours prior to admission faxed to 518-897-5017:**

1. Copy of a current Immunization record. We can not enroll your child without a copy of their immunization record.

2. Copy of the front and back of your prescription card if it differs from medical card.

3. Written prescriptions for all medications and a doctor's note for any over-the-counter medications, vitamins, or supplements. Please see the enclosed note from the Health Team for further explanation.

Any questions pertaining to these requirements or the remainder of the application can be directed to your Admissions Counselor at **877-252-0869**.

Thank You!

Dear Parents,

This is a very important note regarding prescription and over the counter medications used at ALE. Following these instructions will ensure your child has no interruptions in his/her medication regimen. These procedures are mandated to ensure our compliance with all applicable state and federal laws.

- To protect the medications that your child uses from damage and to ensure that your child is receiving the right dose at the right time, all medications will be blister packed. Thus, when medications are sent to the field, they will be packaged by time, dosage, day and week. This system ensures proper medication distribution and care while complying with all federal and state laws. No bottled medications from home, a hospital or any other program that are not blister packed by week will be going to the field at ALE. **– All medications that are used by your child in the program will be filled and packed in a standardized weekly blister pack by a single pharmacy we work with in Saranac Lake.**

- When you send your child please send 3 days of meds. This will give a buffer to cover the transport day, and time to get meds packed after your child arrives. Any additional/leftover medications sent with the student will be returned to you the parent/guardian when your child leaves ALE.

- **Paper originals of all prescriptions need to be sent with your child.** These are required by law for medications to be administered while at ALE.

- We are required by law (while assisting and verifying in the self administration of medications) to give the medications as the prescription reads. If you administer your child's medications differently than the printed prescription reads, please have a new script issued by your physician.

- All Prescriptions and Over the Counter (OTC) medication taken by mouth or used topically also require an original paper script.

- If your child will be arriving with vitamins, or supplements, please include a script. This way they can be packed like medications and fulfill all NY State Department of Health rules and regulations.

- Please ensure that we have a copy of your child's health insurance card as well as their prescription card.

- Again, any additional medications that arrive with your child or that are left over at the end of your child's time at ALE, will be returned to you or your designated agent when the student leaves the program.

  Please call an ALE representative with any questions or concerns.

  Thank You,

  Adirondack Leadership Expeditions Health Team

INSURANCE FORM

Please complete this form in its entirety

- Student's Name: _____
- Insurance Name:_____
- BIN #: _____
- Cardholders ID#: _____
- Group #: _____
- Person Code(if listed): _____
  - ⇒ Please list each applicable individual covered on Insurance and their corresponding code

  Ex. Dad Code #
  Mom Code # etc.
- Home Pharmacy #: _____

AUTHORIZATION FOR USE OF 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:

Patient Name: _____

Persons/Organizations authorized to *use* or *disclose* the information: [1] Adirondack Leadership Expeditions

Persons/Organizations authorized to *receive* the information: Necessary Medical Personnel

Purpose of requested use or disclosure: [2] Informed medical 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

This Authorization expires [insert date or event]: [4] 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: 82 Church Street Saranac Lake, New York 12983

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. [6]

Information disclosed pursuant to this authorization could be re-disclosed by 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 health information that I am being asked to use or disclose.

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: _____

(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 redisclosing such information except with your written authorization or specifically required or permitted by law.)

_____

1 If the Authorization is being requested by the entity holding this information, the 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 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 obtain information in connection with a health plan's eligibility or enrollment determinations relation 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.

The requestor is to complete this section of the form.

NOTICE OF PRIVACY PRACTICES
OF
ASPEN EDUCATION GROUP AND ITS AFFLIATED 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 _____

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 48 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 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 A 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 A, 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 the 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 – Hawthorn Academy, Rossier Park High School and Elementary School, and Leeway School. The reason 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.

RESPONSIBLITIES 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 out 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 other 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 birth 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 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
-- 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 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 ma 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 you 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 service – 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 or 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 patents' 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 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 correctional institution or law enforcement official or 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) protection 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 that 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 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 the 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 our request. We may deny your request for an amendment if it is not in writing or does not include a reason that supports your request. 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 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 the exceptions pursuant to the law. To request this list of 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 Aspen Privacy Officer at (562) 467-5500.

ACKNOWLEDGMENT 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: _____Date: _____
(individual/parent/conservator/guardian)

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: _____

Adirondack Leadership Expeditions
Release of Information Form

82 Church Street
Saranac Lake, NY 12983
Admissions Office: (877) 252-0869 *fax:* (518) 897-5017
E-mail: admissions@adkle.com

Student: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

I/we authorize Adirondack Leadership Expeditions to release any and all information to the referral source listed on this application and all Aspen Education Group (AEG) Programs. I/We authorize the below named educational consultants, professionals and/or institutions to release and receive all information concerning the above named student to and from the Adirondack Leadership Expeditions Adolescent Program and all AEG Programs. 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 care notes and/or academic records.

Please sign even if you do not include Referral Source information

Clinical Resource

_____
Name/Title
_____
Address
_____
City State Zip
_____
Phone/Fax
_____/_____
Inclusive dates of treatment
_____

Clinical Resource

_____
Name/Title
_____
Address
_____
City State Zip
_____
Phone/Fax
_____/_____
Inclusive dates of treatment
_____

Clinical Resource

_____
Name/Title
_____
Address
_____
City State Zip
_____
Phone/Fax
_____/_____
Inclusive dates of treatment
_____

Clinical Resource

_____
Name/Title
_____
Address
_____
City State Zip
_____
Phone/Fax
_____/_____
Inclusive dates of treatment
_____

_____
Parent / Guardian Signature Date

_____
Parent/Guardian Signature Date

Adirondack Leadership Expeditions
Release of Information Form

82 Church Street
Saranac Lake, NY 12983
Admissions Office: (877) 252-0869 *fax:* (518) 897-5017
E-mail: admissions@adkle.com

Student: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

I/we authorize Adirondack Leadership Expeditions to release any and all information to the referral source listed on this application and all Aspen Education Group (AEG) Programs. I/We authorize the below named educational consultants, professionals and/or institutions to release and receive all information concerning the above named student to and from the Adirondack Leadership Expeditions Adolescent Program and all AEG Programs. 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 care notes and/or academic records.

Please sign even if you do not include Referral Source information

Clinical Resource

_____
Name/Title
_____
Address
_____
City State Zip
_____
Phone/Fax
_____/_____
Inclusive dates of treatment
_____

Clinical Resource

_____
Name/Title
_____
Address
_____
City State Zip
_____
Phone/Fax
_____/_____
Inclusive dates of treatment
_____

Clinical Resource

_____
Name/Title
_____
Address
_____
City State Zip
_____
Phone/Fax
_____/_____
Inclusive dates of treatment
_____

Clinical Resource

_____
Name/Title
_____
Address
_____
City State Zip
_____
Phone/Fax
_____/_____
Inclusive dates of treatment
_____

_____
Parent / Guardian Signature Date

_____
Parent/Guardian Signature Date

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 2.31I authorize the release or disclosure of this information after having specifically considering and expressly waiving those federal consent requirements and restrictions.

ADIRONDACK LEADERSHIP EXPEDITIONS
PROGRAM ENROLLMENT AGREEMENT
(ADIRONDACK LEADERSHIP EXPEDITIONS)

This agreement ("Agreement") is entered into by and between Adirondack Leadership Expeditions, LLC, a Delaware limited liability company (hereinafter "Adirondack Leadership Expeditions"), 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 "Sponsor" or "Sponsors"). Sponsor's name (s) is/are: _____. Sponsor's address is: _____ and phone is: _____.

In consideration of the mutual promises set forth in this Agreement, Adirondack Leadership Expeditions and Sponsor (herein after the "Parties") mutually agree as follows:

1. SPONSOR'S REPRESENTATIONS. Sponsor warrants that Sponsor is legally 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 Adirondack Leadership Expeditions 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, Adirondack Leadership Expeditions 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 Adirondack Leadership Expeditions, and Sponsor expressly warrants the truth and accuracy of 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 Adirondack Leadership Expeditions' execution of this Agreement, Adirondack Leadership Expeditions shall accept the Student conditionally for enrollment in the Program, subject to the terms and conditions of this Agreement. Sponsor acknowledges and agrees that Adirondack Leadership Expeditions' conditional acceptance of the Student is subject to the personal evaluation and screening process conducted by Adirondack Leadership Expeditions prior to completion of the Assessment phase of the Program (within the first three (3) days following enrollment). If the Student satisfies Adirondack Leadership Expeditions' screening criteria, Adirondack Leadership Expeditions shall accept the Student and, except as otherwise provided herein, permit the Student to enroll in the Program. If the Student fails to satisfy Adirondack Leadership Expeditions' screening criteria, the Student will be returned promptly to sponsor and Adirondack Leadership Expeditions will also return the prepaid tuition fee to the Sponsor, less days enrolled and deduction for all reasonable expenses incurred by Adirondack Leadership Expeditions on behalf of the Student and/or the Sponsor prior to the Student's return.

3. TERMS OF AGREEMENT. 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 Saranac Lake, New York, 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 control of the Student to Adirondack Leadership Expeditions for the duration of the Agreement, unless either party terminates this Agreement prior thereto by giving written notice to the other party pursuant to terms of the Agreement herein.

4. PROGRAM COSTS AND PAYMENT TERMS.

A. PROGRAM FEES. 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 per day, with a minimum length of stay of twenty-eight (28) days, for a total minimum payment of $13,020 (the "Minimum Payment"). Adirondack Leadership Expeditions reserves the right to expel any student who is not in compliance with the rules and agreements of the Adirondack Leadership Expeditions or whose physical or emotional needs cannot be met by the curriculum offered. Sponsor understands that it is possible to prepay for more than the twenty-eight (28) days covered by the Minimum Payment. Any payment in excess of the Minimum Payment will be refunded if not used. Sponsor further understands that if he or she chooses to extend the initially indicated length of stay at a later time, that ALL

EXTENSIONS ARE BILLED AT A DAILY RATE OF $465 PER DAY. **THE AVERAGE LENGTH OF STAY IS 50-55 DAYS**.

B. OTHER FEES. Sponsor agrees to pay $2200.00 application/enrollment fee and $2500 psychological testing fee.

C. 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 cashiers check, credit card (VISA, MasterCard, and 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.

(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 would result in immediate student discharge.

D. 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 be received within seven days of admission, the student will be discharged prior to 10 days.

E. EARLY WITHDRAWAL OF STUDENT. If Sponsor withdraws Student before expiration of the minimum period of enrollment without the recommendation 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 Saranac Lake, NY, and return transportation to the Student's current residence; all medical, dental, hospital, and related expenses incurred by or for the Student. 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 Adirondack Leadership Expeditions or any third party, and (2) any personal injury to any Adirondack Leadership Expeditions personnel, other students or third parties caused, in whole or part, by the Student; and to promptly reimburse Adirondack Leadership Expeditions 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, Adirondack Leadership Expeditions 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 Adirondack Leadership Expeditions 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. Adirondack Leadership Expeditions 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 Adirondack Leadership Expeditions' subcontracting certain services to be rendered under this Agreement to persons or entities deemed by Adirondack Leadership Expeditions to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. Adirondack Leadership Expeditions is not responsible for the service 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 Adirondack Leadership Expeditions. 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. Adirondack Leadership Expeditions 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. Adirondack Leadership Expeditions 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 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, cross-country skiing, snowshoeing, stress, involvement with other students, self-inflicted injuries, and transportation, whether by bus, train, airplane, or taxi to and from the Program's field location(s) and other locations as reasonably required. 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 any and 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 [facility name] 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 (collectively all of the above persons and entities shall be referred to as the "Released Parties" hereafter) from and against any and all causes of action that may arise in connection with the participation of the student at Adirondack Leadership, whether arising under tort or contract law, except to the extent resulting from the gross negligence or willful misconduct of Adirondack Leadership.

Sponsor intends by this Wavier 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 or 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, except if and only to the extent arising from gross negligence or willful misconduct of Leadership Adirondack Leadership. 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 except and only to the extent expressly stated in this Agreement.

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 student are jointly 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 and unknown (the "Liabilities") arising out of or in connection with claims and/or actions relating to or brought by or on behalf of Student except and only to the extent expressly stated in this Agreement, 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 Adirondack Leadership Expeditions 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 Adirondack Leadership Expeditions' staff; (c) authorize a physician, dentist or other healthcare professional(s) to perform any procedure(s) that the healthcare professional(s) deems necessary for the well-being of the Student; and (d) execute any required authorization to obtain this type of information. Sponsor also authorizes Adirondack Leadership Expeditions to arrange for a physical examination (including a drug screen urine/blood test, at Adirondack Leadership Expeditions' option) and any psychological assessments of the Student deemed necessary by Adirondack Leadership Expeditions prior to the Student's beginning the Program. Sponsor gives permission for Adirondack Leadership Expeditions to obtain a physical exam and will be responsible for any related charges. All costs and expenses incurred for these services shall be the sole responsibility of the Sponsor. Sponsor also authorizes any and all medical doctors, psychologists, counselors, therapists, hospitals, clinics and treatment centers that have treated or counseled the student, and whose names Sponsor shall provide to Adirondack Leadership Expeditions, to release all information regarding the Student's medical and/or psychological history, diagnoses and treatments to Adirondack Leadership Expeditions upon request. Adirondack shall handle all such protected health information ("PHI") pursuant to the guidelines promulgated in the Health Insurance Portability and accountability Act ("HIPAA") of 1996.

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

8. AUTHORIZATION FOR RESTRAINT. Sponsor hereby authorizes Adirondack Leadership Expeditions personnel to physically restrain, control and detain the Student by the exercise of necessary restraints when deemed necessary by Adirondack Leadership Expeditions, 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 or any federal, state, county, or municipal entity are hereby directed to detain and retain custody of the Student until Sponsor or any personnel of Adirondack Leadership Expeditions arrive, at which time Adirondack Leadership Expeditions personnel may re-obtain 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 Adirondack leadership Expeditions 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 ADIRONDACK/LIQUIDATED DAMAGES. Adirondack Leadership Expeditions 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 to Adirondack; physical, medical, mental, or emotional problem(s) of the Student; or (iv) for any other reason if Adirondack Leadership Expeditions deems it necessary for the protection of the Student, any other student(s) or the integrity of Adirondack Leadership Expeditions' Program. **In the event that Adirondack 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 payment and expenses is a reasonable estimate of the losses (i.e., Liquidated Damages) the program incurs with the early termination of the Student.

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

12. ESCORTS. If an escort is required to bring the Student to New York for the Program, Sponsor agrees that any escort or escort service used by the Sponsor, whether or not Sponsor is referred to the escort by Adirondack Leadership Expeditions, is in all respects an independent contractor contracting directly with Sponsor. Sponsor agrees that Adirondack Leadership Expeditions 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, b 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. Student must provide proof of insurance prior to enrollment.

14. EMANCIPATION. Sponsor warrant 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, damages or destruction or unavoidable shutdown 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. BINDING ARBITRATION. Any controversy or claim arising out of or relating to this contract, except at Adirondack Leadership Expeditions' option the collection of monies owed by Sponsor to Adirondack leadership Expeditions, shall be settled by binding arbitration conducted in Lost Angeles, California in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction for purposes of executing upon the award.

17. 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 the 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 cost 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 Adirondack Leadership Expeditions for all reasonable attorneys' fees and costs incurred by Adirondack Leadership Expeditions in connection with those matters concerning which Sponsor has agreed to pay or indemnify Adirondack Leadership Expeditions herein.

18. 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 and 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).

ADIRONDACK LEADERSHIP EXPEDITIONS
17777 Center Court Drive, Suite 300
Cerritos, CA 90703-8567

Parent Name_____
Address_____
_____

19. 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.

20. 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, not shall it be construed as a waiver of any other provision hereof.

21. PARAGRAGH 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.

22. GOVERNING LAW/VENUE. The 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 qualifies (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.

23. SEVERABILITY. In the event that any provision of this Agreement, or any operation contemplated hereunder, is found by a court of competent jurisdiction to by 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.

24. 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.

25. ACKNOWLEDGMENT/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, Adirondack Leadership Expeditions gives no warranties of any kind, express or implied, to wither 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 Adirondack Leadership Expeditions set forth herein.

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

27. 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, Adirondack Leadership Expeditions accepts no responsibility for the mis-transmission that could result in information becoming available to someone other than the intended receiver. Adirondack shall handle all such protected health information ("PHI") pursuant to the guidelines promulgated in the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.

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

_____ _____

Signature Sponsor (Parent/Guardian) Date

_____ _____

Signature Sponsor (Parent/Guardian) Date

ACCEPTED

_____ _____

ADIRONDACK LEADERSHIP EXPEDITIONS Date

Physical Examination Fee Disclosure

Adirondack Leadership Expeditions requires that all students receive a physical examination upon enrollment. The fee for the physical is $150. You, the parent/guardian, will be responsible for submitting the proper documentation to your insurance provider for reimbursement. The Finance Manager will supply you with the required procedure codes. You, the parent/guardian will be responsible for any and all pre-certifications required by your insurance provider. Please contact us for any information you may need in order to pre-certify.

Please note there may be up to a two week delay in billing for the physical exam. Your account will be charged once we received the invoice from the physician's office. If you pay for the physical up front there will be an excess of $150 on your account until it is charged.

Please also note that the State of New York requires the Tetanus vaccination every ten years and the PPD vaccination each year. If your child requires either or both of these vaccinations, additional charges will be incurred based on the current market value of the vaccine.

Acknowledgement of Receipt

_____ _____

Parent Signature Date

****All financial inquiries can be made to our Finance Manager, Brandy Hobson. Brandy can be reached at our office at 518.897.5011. She can also be e-mailed at bhobson@adkle.com****

EXHIBIT A- Enrollment Agreement

I/we understand that the cost of Adirondack Leadership Expeditions is $465 per day, $2,200 enrollment fee, $150 for the physical and $2,500 psychological testing fee. I/we understand that there is a minimum initial payment of **$17,870.00** which covers the first 28 days of the program. 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 IN SEVEN DAY INCREMENTS 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.

Please indicate methods of payment:

☐ **Credit Card**
Amex/Visa/MasterCard Account Number: _____ Exp: _____
3 digit security code:_____
Authorized Signature: _____ Date: _____

☐ **Wire Transfer (PLEASE CALL YOUR ADMISSIONS REPRESENTATIVE FOR WIRE TRANSFER INSTRUCTIONS)**

☐ **Loan (enrollment contingent upon final approval from bank)**

☐ **Cashier's Check** (payable to: Adirondack Leadership Expeditions, c/o Admissions, 82 Church Street, Saranac Lake, NY 12983)

1. My signature below is a formal application to participate with the Adirondack Leadership Expeditions and an understanding of its physical demands.
2. I release Adirondack Leadership Expeditions, its employees, and contractors from any and all liability resulting from our son's/daughter's participation and assume all risks therewith, including known and unknown risks.
3. I understand that even though the program works extremely well, results are not and cannot be guaranteed.
4. **Adirondack Leadership Expeditions charges for 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.**
5. Please note, until we have received your complete application and/or any testing, we cannot assure your child a space for the week requested.
6. Payment must be received prior to course starting date.

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

CREDIT CARD AUTHORIZATION

I hereby give my consent to Adirondack Leadership Expeditions to charge my credit card each week for services rendered and tuition extensions. I understand that if my credit card declines, late fees of $50.00 may be assessed. It is my responsibility to phone the Adirondack Leadership Expeditions Business Office if a card change is needed. I also understand all program costs and the charges as outlined in the financial agreement.

Please charge all program fees and miscellaneous costs (i.e. medical expenses) each week to the following credit card:

Circle one:

Amex Visa MasterCard

Card Number_____ Expiration Date_____

3 digit security code_____

Exact Billing Name and Address as shown on the above credit card statement:

_____

_____

_____

By signing below, I understand and agree to the above statements relating to charges to my credit card and authorize Adirondack Leadership Expeditions to process such transactions related to my child's services and treatment.

Signature of Card Holder_____ **Date**_____

Psychological Testing

The application of scientific methods to understanding
human cognitive, emotional and behavioral functioning

The assessment procedures used will evaluate the child in three major categories:

Cognitive: Determine the strengths and weaknesses of a person's thinking in eleven domains including: general awareness, attention, memory, verbal comprehension, visual-spatial ability, computation, abstract thought, impulsivity, problem solving, social comprehension, and judgment. Obtain level of academic functioning and compare results to nation norms. Rule out learning disabilities, ADD/ADHD, or nonverbal learning disability. Rule out thought disorders and screen for organic impairment.

Emotional: Assess emotional functioning and assess for depression, anxiety, deficits in identity formation, obsessive and compulsive disorders, and sleep disorders. Assess personality functioning. Obtain data regarding developmental and emotional age. Obtain data regarding family dynamics.

Behavioral: Screen for substance abuse. Screen for trauma and abuse. Screen for risk of self-harm, aggression, and treatment compliance or flight. Detect malingering and deceit. Screen for behaviors that are high risk, illegal, or violate the rights of others or major social values.

Assessment results are carefully evaluated and interpreted, and a report is prepared that discusses the findings of the assessment and provides guidance regarding treatment and aftercare.

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 Adirondack Leadership Expeditions. 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 Adirondack Leadership Expeditions to enhance the treatment of the child named below. ALE 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: $2500.00 (In addition to program tuition)

Payment Information

Name of minor: _____ Relationship to minor: _____
Name of parent or guardian: _____

- ☐ Initial Payment
- ☐ Payment by Credit Card (Amex, Visa or MasterCard)
  Card Number: _____ Exp. Date_____
  3 digit security code_____
- ☐ Cashiers Check (payable to: Adirondack Leadership Expeditions, c/o Admissions, 82 Church Street, Saranac Lake, NY 12983)

Signature: _____ Date: _____

If you have questions, please speak with your Admissions Counselor.

Adirondack Leadership Expeditions

SAFETY PROVISIONS & PARENT AUTHORIZATION & CONSENT

Inasmuch as I have enrolled my son/daughter (full name) _____ in the Adirondack Leadership Expeditions Adolescent Program for the (dates) _____ to _____ class, and understanding that the program to be conducted in New York is a rigorous physical and emotional experience for youth, and realizing that Adirondack Leadership Expeditions has exclusive control of (full name) _____ during this time, I approve and give my consent to the following safety procedures to ensure the well-being of all participants:

- My/Our child's personal effects and his/her person may be searched at the discretion of Adirondack Leadership Expeditions personnel for the exclusive purpose of discovering any prescribed or non prescribed drugs or medications and that all prescribed medications to be taken by my/our child during the course of the expedition be in custody and dispensed by Adirondack Leadership Expeditions personnel.

- I understand that incoming and outgoing mail from students to parents, guardians and attorneys shall not be restricted or censored. Mail to parents, guardians, and attorneys will be reviewed by staff and sent without alteration to intended recipient. All other mail may be restricted by parental request. All incoming mail will be opened by staff and reviewed and then given to the student, with any contraband being confiscated or stored in my personal belongings.

- 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 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 Adirondack Leadership Expeditions on the Parent Concern Questionnaire, are hereby authorized to release all information regarding medical history, diagnosis, treatment, or disability to Adirondack Leadership Expeditions 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 Adirondack Leadership Expeditions staff during the term of the 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 Adirondack Expeditions personnel are contacted, at which time Adirondack Leadership Expeditions personnel may re-obtain 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 Adirondack Leadership Expeditions personnel shall be able to physically restrain, control, and detain my/our child for the following purposes:

    - 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 Adirondack Leadership Expeditions 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.
    - To prevent students from hurting or jeopardizing the safety of themselves or 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 Name- Mother **Father** **Date**

_____ _____ _____

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

_____

Full Address **City** **State** **Zip**

Adirondack Leadership Expeditions

Parent Authorization and Consent for Electronic Communications

I/we authorize Adirondack Leadership Expeditions to transmit personal communications from my child to me by facsimile or email.

Please fax all student communications to me at the following number:

FAX NUMBER: _____ or if fax is not preferred,

EMAIL ADDRESS: _____

Circle one of the following:

SECURE **The above fax/email is secure please fax without notification.**

NOT SECURE **The above fax/email is NOT SECURE, please contact me at the following number prior to any transmission.**

Call to Notify at: _____

TRANSMISSION ERRORS

I/we understand that errors sometimes occur in the transmission of personal communications between children and parents. I/we release Adirondack Leadership Expeditions from any and all liability for errors in the transmission of personal communications between my child and myself.

I/we agree to keep confidential the nature of any communication that I/we may receive in error and to notify Adirondack Leadership Expeditions immediately.

_____

Mother (Print Please) **Father (Print Please)** Date

_____

Mother (Signature) **Father (Signature)** Date

STUDENT EMERGENCY – SUMMARY INFORMATION

STUDENT'S NAME: _____

Please List Any MEDICATIONS that your Child is CURRENTLY taking and bringing:

Medication	Dosage/Amount Sending	AM/PM	Date Prescribed	Reason Taking

Please list any previously experienced Medication reactions/side effects:

_____

Does your Child have a History of Refusing to take Medication? If so, Please List what reactions, or side effects might occur:

_____

All Medication "MUST" include a Prescription & be in the correct Containers. All medications (including Vitamins & Acne Creams) must include clear doctor's prescriptions, or they can not be dispensed.

Please list any major illness or physical injury that was suffered by your child previously:

_____

_____

Please List Any ALLERGIES, SPECIAL MEDICAL CONDITIONS OR DIETARY CONCERNS that effect your Child, including reactions to POISON IVY:

Allergy/Condition	Specify Reactions & History

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

Prescription Eyewear	Yes	No	Glasses Preferred
Dental Retainer	Yes	No	Please Send Container

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

_____

_____

Adirondack Leadership Expeditions
Parent Admission Information

Adirondack Leadership Expeditions will be responsible for contacting parents or legal guardian with admission information upon your child's date of arrival. This contact will include information regarding frequency of service plan contact and the scheduling of an initial appointment.

Parents agree to be responsible for contacting Adirondack Leadership Expeditions at scheduled appointment times for Service plan contact calls. Service plan contact will cover information relating to your child's care, including, but not limited to their psychological, developmental, educational and medical needs.

Adirondack Leadership Expeditions is not a religious based organization and is committed to respecting the backgrounds and traditions of our clients and families. Parents agree to inform Adirondack Leadership Expeditions of any special requirements prior to admission.

Adirondack Leadership Expeditions offers face-to-face interviews with parents and/or child if convenient to parents and so requested, prior to the child's admission.

Parents agree to participate in scheduled weekly service plan meetings, to complete therapeutic assignments and a family workshop on the day of discharge.

Adirondack Leadership Expeditions will copy all therapeutic communication (i.e. letters and e-mails) and place in the child's chart.

Adirondack Leadership Expeditions will make aftercare recommendations to parents or legal guardians prior to program completion during service plan contacts. A written record of recommendations will be forwarded after completion in a reasonable period of time.

I understand the above specified admissions information and acknowledge that I have discussed this with my admissions counselor.

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

PARTICIPANT NAME: _____

DATE: _____

Dear Parent,

The State of New York requires all outdoor programs and overnight camps with students who attend for more than 7 days to inform parents/guardians about meningococcal disease, a bacterial infection often referred to as meningitis, and vaccination options.

Currently, there are no data suggesting that children at overnight camps and residential schools are increased risk, as has been associated with college students, specifically freshmen living in dormitories. This is just a precaution because children attending these programs can be in settings similar to college students living in dormitories. Meningitis is transmitted by direct close contact with nose and throat discharges of an infected person.

Meningitis is rare. However, when it strikes it can be difficult to diagnose due to its flu-like symptoms. Meningitis is a bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord). Anyone can get meningitis but it is more common in infants and children. As mentioned previously, there has found to be an increased risk for some college students, more specifically, freshman living in dormitories.

A safe and effective vaccine is available for the prevention of Meningitis. The vaccine is 85% to 100% effective and is accompanied only by mild and infrequent side effects of pain and redness at the injection site which lasts up to two days. For more information, you can contact your family physician or visit the manufacturer's website at www.meningitisvaccine.com. The medical professional who completes your child's intake physical can discuss this with you further, and is available to administer the vaccine for an additional charge of $130 if you so desire.

Adirondack Leadership Expeditions is required to maintain a record of the following for each student:

- Documentation signed by the student's parent or guardian acknowledging receipt of information about meningitis and the availability and cost of the Menactra vaccine.

Adirondack Leadership also requires ONE OF THE FOLLOWING:

- A record of meningococcal meningitis immunization within the past 10 years, OR

- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student's parent or guardian, OR

- A request that the vaccine be administered as part of the child's admission to the program

Please review and return the **Meningococcal Vaccination Response Form** along with completed application materials. Please contact me at (518) 891-3060 or consult your child's physician if you have any questions or concerns about this information.

Sincerely,

Health Director, Adirondack Leadership Expeditions.

Meningococcal Meningitis Vaccine Response Form

PLEASE CHECK ONE AND SIGN BELOW

_____ My child has had the meningococcal meningitis immunization (Menactra) within the past 10 years and I have enclosed record of the administration.

Date received: _____

_____ I have read, or have had explained to me the information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease at this time.

_____ I request that my child receive the Menactra vaccine as a part of her/his admission to the Adirondack Leadership Expeditions program.

_____
(Parent/Guardian Print)

_____ _____
(Parent/Guardian Signature) (Date)