Southwest Open School
Student Application form 2023-234

Student Information Date _____

Last Name _____ Age _____

Full Middle Name _____ Birth Date _____

First Name _____ Gender: ___Female ___Male ___Other Other
Preferred Name if Different _____

I would like more information about a Gender Support Plan (GSP) YES _____ NO _____

Street Address _____ E-Mail _____

Mailing Address _____ Phone _____

City _____ State _____ Zip_____ Cell Phone _____

Do you consider yourself to be of Hispanic/Latino origin? YES _____ NO _____

Which of the following groups describe your Ethnicity? – (you may select more than one if applicable)

(01) American Indian or Alaskan Native: Navajo ___ Ute Mountain ____ Northern Ute ___ Southern Ute ___ Other ___

(02) Asian _____

(03) Black or African American _____

(04) Hispanic of any race _____

(05) White _____

(06) Native Hawaiian or Other Pacific Islander _____

(07) Two or more races _____

Parent/Guardian Information

Parent 1/Guardian _____ Parent 2/Guardian _____

Mailing Address _____ Mailing Address _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

Cell Phone _____ Cell Phone _____

Email Address _____ Email Address _____

Please sign below to indicate that you have read the entire student application packet and provided the correct information needed to enroll your child in Southwest Open School.

_____ _____
Student Signature Parent Signature

SWOS should mail information to: Parent 1 Parent 2 Both

Student lives with: Parent 1 Parent 2 Both Neither

If the student **does not live with parents**, please fill out the following information on the people with whom the student lives:

Name _____ Relationship _____

Address _____ City _____ State ____ Zip _____

Emergency Contact Information

The individuals listed below have the authorization to pick up my child and can be reached during school hours at the numbers listed below:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Education Background Information

Last school you attended _____ Year _____

School Address _____ City _____ State _____ Zip _____

School Phone _____ School Fax _____

Last grade enrolled in: 8 9 10 11 12

Number of High School Credits _____ Have you passed the GED? Yes No

Are you planning on utilizing the RE-1 School bus to and from school? Yes No

Have you ever been suspended from school? Yes No How many times? _____

Have you ever been expelled from school? Yes No What grade were you in? _____

SOUTHWEST OPEN SCHOOL

Student Use of the Internet and Electronic Communications

Student Name:_____ (printed)

If you are 18 years old or older:

I have read, understand and will abide by the district's policy of Student Use of the Internet and Electronic Communications. Should I commit any violation or in any way misuse my access to the school district's computers or computer system, including use of the Internet and electronic communications, I understand and agree that my access privileges may be revoked and disciplinary and/or legal action may be taken.

If I am 18 years or older, I hereby release the school district from all costs, claims, damages or losses resulting from my use of district computers and computer systems, including use of the Internet and electronic communications, including but not limited to any user fees or charges incurred through the purchase of goods or services.

Your signature on this Acceptable Use Agreement is binding and indicates you have read the school district's policy on Student Use of the Internet and Electronic Communications and understand its significance.

_____ _____

Student's Signature Date of Birth (day/ mo/yr)

If the user is <u>under 18 years of age</u>, a parent or guardian must also sign this Agreement.

As the parent or guardian of this student, I have read the district's policy on Student Use of the Internet and Electronic communications. I understand that access to the Internet and electronic communications is designed for educational purposes and that the school district has taken reasonable steps to block or filter material and information that is obscene, child pornography or otherwise harmful to minors, as defined by the Board. I also recognize, however, that it is impossible for the school district to prevent access to all materials or information I might find harmful or controversial and I agree not to hold the district responsible for any such materials and information accessed by my child. Further, I accept full responsibility for supervision if and when my child's Internet or electronic communications use is not in a school setting.

I hereby release the school district from all costs, claims, damages or losses resulting from my child's use of district computers and computer systems, including use of the Internet and electronic communications, including but not limited to any user fees or charges incurred through the purchase of goods or services.

I hereby give permission to issue an Internet and electronic communications account for my child and certify that the information contained on this form is true and correct.

Your signature on this Acceptable Use Agreement is binding and indicates you have read the district's policy on Student Use of the Internet and Electronic Communications carefully and understand its significance.

_____ _____

Parent/Guardian's Name (printed) Date

_____

Parent/Guardian's Signature

SOUTHWEST OPEN SCHOOL

Notice of Trip Procedures Regarding Illegal Substance Possession/Use

While your child is a student at SWOS, it is highly likely that he/she will be taking a trip with their class. Class trips are an important part of the curriculum and it is expected that students participate in trips that are a part of their class content. Parents receive a trip itinerary and information regarding the trip. Teachers are available to answer any questions parents may have concerning trips both before and after the trip.

While a student is on a SWOS trip, it is imperative that a high trust level be established between staff and students. When SWOS staff takes your child on a trip, all SWOS norms must be followed. It is illegal for students to possess or use drugs or alcohol on the school grounds or on any school sponsored activity. If a student possesses or uses drugs or alcohol on a SWOS trip, that student will be subject to discipline, up to and including expulsion from SWOS for the remainder of the school year. The parent is immediately notified and will become responsible for transporting that student home. Please sign the form below to indicate that you understand you will take over responsibility for your child if they possess or use illegal substances on a SWOS trip.

I understand that I will have to accept full responsibility for my child if he/she chooses to possess or use illegal substances on a SWOS trip. This means I will have to make immediate arrangements for my child to be transported back home ASAP.

_____ _____

Child's Name Parent/Guardian Name

_____ _____

Parent/Guardian Signature Date

PHOTOGRAPHY CONSENT FORM RELEASE

I *(print name)* _____, hereby grant permission to Southwest Open High School, its employees or representatives, to take and use:

photographs
videotape
digital images

of me for use in promotional or educational materials. These materials might include printed or electronic publications, websites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the images (s). I authorize the use of these images indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and videotape shall be the property of Southwest Open School.

_____
(Date)

_____
(Signature of adult subject)

_____
(Address)

_____
(City, State, Zip)

****

RELEASE OF MINOR CHILDREN (Under 18)

I *(print name)* _____, parent or official guardian of (child's name) _____ hereby grant permission to Southwest Open School, its employees or representatives, to take and use:

photographs
videotape
digital images

of my child for use in promotional or educational materials as follows:

printed publications or materials
electronic publications or presentations
web sites

I agree that my child's name and identity:

may be revealed
may **not be** revealed

in descriptive text or commentary in connection with the image(s). I authorize the use of these images indefinitely without compensation to me. All negatives, positives, digital reproductions and videotape shall be the property of Southwest Open School.

_____
(Signature of Parent or Guardian) *(Date)*

_____
(Address City, State, Zip)

SOUTHWEST OPEN SCHOOL:
ACKNOWLEDGMENT & ASSUMPTION OF RISKS AND RELEASE & INDEMNITY AGREEMENT

INTRODUCTION

Please read this entire Acknowledgment & Assumption of Risks and Release & Indemnity Agreement (hereafter, "Document") carefully before signing. The student (hereafter, "participant") must sign this Document. If participant is under 18 years of age (hereafter sometimes "minor" or "child"), one of the participant's parents or legal guardians, or both (hereafter collectively "parent/s"), if available, must also sign. In consideration of the services of Southwest Open School, a 501(c)(3) non-profit charter school association (referred to in this Document as "SWOS"), in allowing participant to participate, I (participant and parent/s of a minor participant) acknowledge and agree as follows:

ACTIVITIES, RISKS AND ACKNOWLEDGMENT AND ASSUMPTION OF RISKS

Participating (whether simply attending, observing or actively participating) in SWOS year-round educational, experiential, instructional, recreation and/or adventure activities associated with academic programs, curricular or co-curricular activities or otherwise, includes risks. These activities can take place on or off SWOS premises in Colorado or in other locations in the United States and/or in foreign countries. Activities, which may be led or conducted by SWOS staff, volunteers, contractors or others, may include, but are not limited to: classroom activities; competitive or non-competitive athletic sports and/or games, practices and events; P.E. and other athletic activities, including use of weights and weight room activities; hiking; backpacking; camping (winter and summer); cross-country, alpine or back-country skiing, snowshoeing, snowboarding and other outdoor winter activities; rock climbing or bouldering (indoors or outdoors on artificial surfaces or natural rock), canyoneering and use of low or high ropes courses, challenge courses or zip lines (all of which may include use of ropes, harnesses and/or other technical gear); rafting, kayaking, canoeing, or other boating, including riding in chartered motor boats; swimming in pools, rivers, lakes, and/or oceans; road and mountain bicycling; urban and/or trail running; horseback riding; archery; welding; glass blowing; day or multi-day field trips or other trips; service learning projects; SWOS club or intramural activities; use of homestays and other accommodations; use of any equipment, facilities or premises; travel in airplanes, vans, buses or other vehicles to and from SWOS or during trips, events or otherwise (collectively referred to in this Document as "activities"). Activities may take place as mandatory or optional segments during the SWOS academic year or summer curriculum, and may be scheduled or unscheduled, supervised or unsupervised, and include activities undertaken during participant's free and/or independent time. Participant and parent/s of a minor acknowledge that participant's choice to socialize or participate in activities with SWOS staff members outside school hours and/or unrelated to a SWOS organized field trip, outing or program is not a SWOS related activity, and participant does so entirely at their own risk. **I, (and my parent/s, if I am a minor) acknowledge that the inherent and other risks, hazards and dangers (collectively referred to in this Document as "risks") of these activities can cause injury, damage, death or other loss to participant or others.** Parent/s of minor participants agree to discuss the nature of these activities and risks with their child and give their child permission to participate in all SWOS activities. **The following describes some, but not all of those risks:**

Risks present in an outdoor environment. These risks include travel in high altitude (up to or possibly above 13,000 ft.), mountainous, desert and/or wilderness terrain, both on and off trail and on land or water. Participants' travel may be subject to storms, including rain, lightning, strong winds, snow or ice; tides, currents, waves, reefs or whitewater; extremely hot (geothermal) or cold water or weather and rapid and unpredictable weather changes; flash floods; mud or rock slides; fast moving rivers, oceans or other water bodies; difficult stream and/or snowbridge crossings; falling or slippery rocks; falling or fallen timber; avalanche dangers; stinging, venomous and/or disease carrying animals, insects or microorganisms; poisonous plants; wild or domestic animals and other natural or man-made hazards. Hazards (both on land and above or below water level) may not be marked or visible and weather is always unpredictable.

Equine risks. Riding or dealing in any way with horses (including donkeys, mules or ponies) includes risks. Horses are unpredictable in all circumstances and, without warning, can kick, bite, stomp, stumble, rear, bolt, fall down, and react to the environment, sudden movements, noise, light, vehicles, people, other animals or objects. Horseback riding can involve equipment that may fail, saddles that may slip and other riders who may not control their animals. **WARNING: Under Colorado law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to section 13-21-119, Colorado Revised Statutes.**

Decision making and conduct risks. These risks include the risk that the participant or a fellow participant, SWOS staff member, contractor, or other person may misjudge the participant's (or others) capabilities, health or physical condition, or misjudge some aspect of travel, instruction, medical treatment, weather, terrain, water conditions or water level or route location. **These risks also include the participant's judgment in managing his or her own health issues, including any responsibility for self-medication.**

Personal health and participation risks. The participant's mental, physical or emotional condition (including use or abuse of alcohol or any prescription or non-prescription drugs), disclosed or undisclosed, known or unknown, combined with participation in these activities includes risks. **Although SWOS personnel may review participant's health and medical information, SWOS cannot anticipate or eliminate risks or complications posed by participant's mental, physical (including fitness level) or emotional condition.**

Risks associated with any active, athletic and/or competitive activity. Participating in, training or conditioning for, and/or practicing and competing in any activities can involve frequent and repetitive use of the arms and legs, lifting or carrying weight, balancing, coordination and endurance. Risks include that a participant may overestimate his or her abilities or fitness; be inattentive; lose control and trip or fall and/or collide with others, the ground, rocks or trees or encounter other water/terrain/road/trail/other hazards; not understand the functioning of (or misuse) the equipment; fail to negotiate steep, uneven or difficult terrain; not control his or her speed or experience equipment malfunction.

Service learning project risks. Risks include those associated with activities such as building, digging, lifting, construction, maintenance and repair (including trail work). Projects may involve the use of tools and equipment (i.e. hand tools, power tools, hammers, ladders) and substances (paints, cleaning agents) that can cause injury resulting from use, misuse or malfunction.

Geographic location risks. Activities may take place in remote locations, several hours or up to a day from medical facilities, causing potential delays or difficulties in communication, transportation, evacuation and medical care. Medical facilities may sometimes be primitive, inadequate or inaccessible. Additional delays can result if circumstances require transport from a foreign country back to the U.S. for medical care. Although SWOS staff or contractors may have access to wireless communication devices, use of these devices (whether inside or outside the U.S.) in outdoor or wilderness terrain and/or in any other terrain or location is unreliable and inconsistent.

Risks associated with premises. Participants may cook, or engage in other chores on SWOS premises. In addition, boulders, ruts, slippery walkways, uneven ground or other conditions may exist in and around the SWOS grounds.

Equipment risks. The risk that equipment used in an activity may be misused, or may break, fail or malfunction. This includes participant's personal equipment, SWOS equipment or any other equipment (whether purchased, borrowed, or rented). Participants choosing to bring and use their personal equipment (including any safety gear) assume full responsibility, along with parent/s of minors, for choosing appropriate equipment and for the fit and condition of their equipment. Helmets or other safety gear (required or used for some activities) may prevent or lessen injuries in some instances; however, use of safety gear is not a guarantee of safety, and injury can occur even with the use of this gear.

Boating and swimming risks. These risks include potential water obstacles or hazards such as rapids, boulders, trees/bushes and branches, ropes, fences, other boats; waterfalls, holes, reversals; slipping on wet rocks or boat ramps or jumping off rocks into the water; falling overboard; impact with rocks/equipment/the river bottom/other people; being swept into a river current; or experiencing a boat capsize or collision.

Climbing risks. Whether climbing, or using zip lines or ropes or challenge courses, risks include the possibility of slipping and falling partway or to the ground; burns; pinches; jolts; belayer inattention or error; losing grip on the rock or a climbing hold; impacting the rock face, a climbing tower, cable, objects or people; being hit by rock or debris fall from above; loose or damaged climbing holds; and equipment failure or misuse.

Cooking, camping and travel risks. While camping or otherwise, participants may cook over a gas or propane stove and are subject to the risk of gas explosion, scalding or other burns. Contaminated water is a risk in natural or primitive settings and water may be disinfected, filtered or boiled before use. Food or water is also provided by vendors, contractors, host families or public restaurants with risks of contamination or allergic reaction. Camp sites may be subject to falling trees and/or branches, floods, wildlife disturbances, and other hazards.

Free or unsupervised time. Participants may have free or unsupervised time during sleeping hours, before, during and after the start of an activity, and at various other times. Unsupervised time may include free time and/or brief periods of time outdoors, stationary and alone (solo). **During both supervised and unsupervised activities, all participants share in the responsibility for their own well-being.**

U.S. and International travel risks. Travel inside or outside the U.S. can involve unique risks such as political unrest, terrorism, contact with unusual diseases, exposure to contaminated food or water, dangerous road or travel conditions, thievery, abduction and other risks. Participants may be subject to laws and legal systems in foreign countries that do not provide the same protections as the U.S. legal system. **NOTE:** Although SWOS considers current geo-political climates in choosing international program locations, SWOS personnel are not experts in assessing the likelihood of terrorist activity, political unrest, the need for vaccinations or other issues. **The participant and his or her parent/s are responsible for conducting their own independent investigation through the U.S. State Department, U.S. Centers for Disease Control, World Health Organization or other sources, should they have any concerns about program locations.**

Risks regarding conduct. The potential that the participant, other participants or third parties, may act carelessly or recklessly.

These and other risks may result in participants: falling partway or falling to the ground or into the water; being struck by, colliding with or impacting objects, people, vehicles, animals, the rock face or the bottom of a water body; experiencing vehicle or boat collision, capsize or rollover; getting caught or entangled in objects above or below water; reacting to high altitudes, weather conditions or increased exertion; becoming lost or disoriented; suffering gastro-intestinal complications or allergic reactions or experiencing other problems. These and other circumstances may cause heat or cold related illnesses or conditions (including hypothermia, hyperthermia, cold water immersion, frostbite or heat exhaustion/stroke); dehydration; hyponatremia; drowning; high altitude sickness (e.g. high altitude pulmonary or cerebral edema); heart or lung complications; broken bones; paralysis or other permanent disability; mental or emotional trauma; concussions; sun burn or other burns; illnesses (including contracting animal/insect borne or contagious diseases); infections; cuts; wounds; or other injury, damage, death or loss.

I (participant and parent/s of a minor participant) agree:

- to accurately review all information received, complete and abide by all required forms, and obey SWOS rules and other policies;
- SWOS representatives are available should I have further questions about these activities or the associated risks;
- to disclose any mental, physical or emotional condition/s or limitation/s which might affect participant's ability to participate, and represent that participant is fully capable of participating without causing harm to him/ her/their self or others;
- participant and parent/s of a minor are responsible for any lost, stolen or damaged equipment;
- SWOS contracts with individuals or organizations that are independent contractors (not employees or agents of SWOS) to provide or conduct some of the services and activities participants will engage in. SWOS does not supervise or control these contractors and is not legally liable or responsible for their conduct. In addition, organized and/or competitive activities, including competitions, meets, events and races are often organized by third parties and/or take place on premises or at facilities not owned by, or associated or affiliated with, SWOS. SWOS does not oversee, supervise, or take responsibility for any aspect or condition of these independent services, activities, facilities or premises. Participant and parent/s of a minor acknowledge that they may independently inspect and assess any of these services, activities, facilities or premises, if they choose to do so;
- the information provided above is not complete, other unknown or unanticipated activities, risks and outcomes may exist, and SWOS cannot assure participant's safety or eliminate any of these risks.

Participant is voluntarily participating with knowledge of the risks. Therefore, participant (and parent/s of a minor) assume and accept full responsibility for participant, for the inherent and other risks (known and unknown, described above or otherwise) of these activities and for any injury, damage, death or other loss suffered by participant (and parent/s of a minor), resulting from those risks, including the risk of participant's own negligence or other misconduct.

RELEASE AND INDEMNITY AGREEMENT

Please read carefully. This Release and Indemnity Agreement contains a surrender of certain legal rights. I (adult participant, or parent/s for themselves and for and on behalf of their participating minor child) agree as follows:

1) to release and agree not to sue SWOS, the Montezuma Cortez RE-1 School District, and each of their respective officers, directors, teachers or other employees, agents, representatives and volunteers, including but not limited to leaders, guides and mentors, and all related or affiliated individuals or entities (hereafter individually and collectively "Released Parties"), with respect to any and all claims, liabilities, suits or expenses (including attorneys' fees and costs) (hereafter "claim" or "claim/s"), for any injury, damage, death or other loss in any way connected with my/my child's enrollment or participation in these activities, including use of any equipment, facilities or premises. **I understand I agree here to waive all claim/s I or my child may have against the Released Parties, bind my/my child's estate and any family member/heir/other party bringing claim/s, and agree that neither I, my child nor anyone acting on my or my child's behalf, will make a claim against the Released Parties as a result of any injury, damage, death or other loss suffered by me or my child;**

2) to defend and indemnify the Released Parties ("indemnify" meaning protect by reimbursement or payment), with respect to any and all claim/s brought by or on behalf of me, my participating child or spouse, my/my child's other family member/s, heir/s or estate, a co-participant or any other person for any injury, damage, death or other loss in any way connected with my/my child's enrollment or participation in these activities, including use of any equipment, facilities or premises.

This Release and Indemnity Agreement includes claim/s of or resulting from the Released Parties' negligence (but not any of their gross negligence or willful, wanton or reckless misconduct), and includes claim/s for personal injury or wrongful death (including claim/s related to emergency, medical, drug and/or health issues, response, assessment or treatment), property damage, loss of consortium, breach of contract or any other claim.

***OTHER PROVISIONS*: I (participant and parent/s of a minor participant) further agree:**

- Colorado substantive law (without regard to its "conflict of law" rules) governs this Document, any dispute I or my child have with the Released Parties and all other aspects of my or my child's relationship with the Released Parties, contractual or otherwise, and I agree that any mediation, suit or other proceeding must be filed or entered into only in Montezuma County, Colorado. I agree to attempt to settle any dispute (not settled by discussion) through mediation before a mutually acceptable Colorado mediator;
- I authorize SWOS staff, representatives, contractors or other medical personnel to obtain or provide medical care for me/my child, to transport me/my child to a medical facility, and to provide treatment they consider necessary for my/my child's health. I agree to pay all costs associated with that care and transportation. I agree to the release (to or by SWOS) of any medical records necessary for treatment, referral, billing or insurance purposes;
- SWOS reserves the right to remove any participant from any activities, if staff believe, in their judgment, the participant presents a safety concern or medical risk, is disruptive, or engages in illegal or offensive conduct. Use of illegal drugs, tobacco products or alcohol are examples of conduct that can lead to early dismissal. If participant is dismissed or departs for any reason, participant (and his/her/their family) are responsible for all costs of early departure whether for medical reasons, dismissal, personal emergencies or otherwise;
- I authorize SWOS or parties it designates the right and permission to photograph, film, record and/or otherwise capture my or my child's name, image, voice, written statement, photograph and/or visual likeness and use those in any media throughout the world, in perpetuity, including for reproduction, display or otherwise on the worldwide web or in publications, film or other form for educational, promotional or other purposes, without compensation to me or my child. I agree that SWOS owns all ownership/copyright rights and I waive any privacy, inspection or approval rights;
- This Document is intended to be interpreted and enforced to the fullest extent allowed by law. If any portion of this Document is deemed unlawful or unenforceable, it shall not affect the remaining provisions, and those remaining provisions shall continue in full force and effect;
- this Document is effective in regard to the participant's enrollment or participation in all activities from the date signed until a subsequent SWOS Acknowledgment and Assumption of Risks & Release and Indemnity Agreement is signed by the participant (and parent/s of a minor participant), and shall remain in full force and effect for all activities completed by the participant up until that point.

<u>Participant and parent/s of a minor participant</u>: I have carefully read, understand and voluntarily sign this Document and acknowledge that it shall be effective and legally binding upon me, my spouse, participating minor child and other children, and parent/s/participant's other family members, heirs, executors, representatives, subrogors, assigns and estate. The participant must sign below. If participant is a minor (under 18 yrs. of age), one of the minor's parents or legal guardians, or both, if available, must also sign below.

_____

Participant Signature Date Print name here

_____

1st Parent or Guardian Signature Date Print name here 2nd Parent or Guardian Signature Date Print name here

Southwest Open School

401 N. Dolores Road
Cortez, CO 81321

Phone 970-565-1150
Fax 970-565-8770

PERMISSION TO TREAT FOR ILLNESS OR INJURY AND SECURE EMERGENCY SERVICES

I give my permission for my child_____ to participate in any Southwest Open School (SWOS) field trips. In the unlikely event of an accident involving my child, I request that the trip leader (s) secure emergency services (including rescue, evacuation, and medical treatment) for my child and grant them legal permission to sign for such emergency services. I agree to incur any additional expenses associated with such action. As parents/guardians, we understand that field trips are a significant part of SWOS curriculum. I have decided that our child is physically, mentally, and socially able to participate in these field trips. I acknowledge that any medical or accident insurance we consider necessary will be our responsibility to locate and purchase. I have read and agree to these terms and do hereby release SWOS and its employees and volunteers from liability for damages, injuries, or losses that may occur while my child is on a SWOS field trip.

SWOS staff has my permission to give my child:

Tylenol _____ Ibuprofen _____ Antacids _____ Cough Drops _____

_____ _____
Parent/Guardian Date

In an emergency, contact me at: _____

If you cannot reach me, please contact _____ at_____.

Note: The Colorado Division of Wildlife is an excellent source of rescue insurance. All hunting and fishing licenses contain a .25 cent surcharge to cover rescue costs. The Division also sells hiking certificates, good for five years, that provide the same coverage. We encourage all parents to obtain this coverage, not just for SWOS but for all outdoor activities.
Inexpensive medical insurance is available through the school district.

Southwest Open School

401 N. Dolores Road
Cortez, CO 81321

Phone 970-565-1150
Fax 970-565-8770

SWOS Insurance and Liability Form

The following form is required for participation in the Southwest Open School program.

Your signature at the bottom of this form affirms that you have read and understood the following:

1. I am aware that SWOS does not provide liability medical coverage for my child during this program. At SWOS, my child will be involved in on-campus and off-campus activities that involve some inherent risk.
2. It is recommended that your child be covered by a major medical insurance policy during the school year. If you do not have major medical insurance for your child for this program, inexpensive medical insurance is offered through the Montezuma-Cortez School District RE-1. It is recommended that you choose a 24-hour coverage, available through GTL Insurance Company (Call SWOS for GTL form). I understand that school insurance is available. I _____ choose or _____ do not choose to purchase school insurance for my child.
3. My son/daughter, _____, is adequately covered by major medical insurance policy during the times of the above program dates. Listed below is our insurance policy information. Listed below is our insurance policy information.
   Name and address of Insurance Company responsible for medical expenses:

Name _____

Address _____ City _____ State _____ Zip _____

Phone# _____ Policy Number _____

_____ Initial here if you do not have any insurance. As the parent/guardian, I will be responsible for any medical payments that might arise.

_____ _____

Signature of Parent or Guardian Date

_____

Permission to Leave Campus

My child, _____, **is under 16 years of age** and has my permission to leave campus during school hours (lunch hour/break) for non-school activities.

_____ _____

Parent/Guardian Date

Southwest Open School

401 N. Dolores Road
Cortez, CO 81321

Phone 970-565-1150
Fax 970-565-8770

***** Please note all parents must complete this form and sign and date it*****

Southwest Open School

Medicaid Consent Form

The federal MEDICAID program has instituted a special program whereby school districts may seek reimbursement for health-related services provided by school districts to children with MEDICAID health insurance. Such services include, but are not limited to: assessments and evaluations, nursing services, speech, occupational and physical therapy, and psychological or social work services as part of an individual student's education or health plan. Your child will continue to receive services at no cost to you under this new program. This new program simply helps us maximize federal funds in support of local education. Granting the district permission to receive these federal MEDICAID funds in no way limits any other MEDICAID benefits you child receives outside of school. However, giving your child consent will help our school district expand health and health-related services for all children.

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVICES

PARENT/GUARDIAN _____
(Name of parent or person in parental relationship – PLEASE PRINT)

CHILD'S NAME _____
(First Name-Middle Initial-Last Name – PLEASE PRINT)

CHILD'S DATE OF BIRTH ____/____/____

CHILD'S SOCIAL SECURITY NUMBER ____ ____ ____ - ____ ____ - ____ ____ ____ ____

CHILD'S MEDICAID NUMBER ____ ____ ____ ____ ____ ____ ____ ____ (If currently eligible)

CHILD IS NOT CURRENTLY ELIGIBLE _____ (Please check here is child is not currently eligible.)

A parent/guardian of the child named above, I give the school district permission to release information related to health services he/she has received at school to local, state, and/or federal MEDICAID representatives for the sole purpose of allowing the school district to seek reimbursement from MEDICAID for those health services.

Signature _____ Date _____

* If at some time you wish to withdraw this permission, please contact the school building nurse*

Armed Forces Recruiting
Important Notice to Parents – Armed Forces Recruiter Access to Students & Student Recruiting Info

The "No Child Left Behind Act of 2001" passed certain new requirements with respect to Armed Forces Recruiter Access to Students and Student Recruiting Information:

- Duty to provide information to Military Recruiters: Unless the parent otherwise request, the District must provide upon request by military recruiters access to high school student's name, address and telephone listings.
- Consent: Either the high school student or the parent of the student may request that the student's name, address and telephone listing not be released without the prior parent consent. Schools are required to notify parents of this option to make a request and shall comply with the request.
- Access to students: Each district shall provide military recruiters the same access to high school students as is provided generally to higher education institutions, community colleges and prospective employers.

If you do not want your student's name, address and telephone listing released to Armed Forces recruiters, YOU MUST SIGN AND RETURN THIS FORM.

Your statement of objections will placed in your child's records, and we will not release this information to military recruiters without your written consent.

DO NOT RELEASE MY STUDENT'S INFORMATION

As parent/guardian of _____ I **do not** give permission for the Southwest Open High School to release any information regarding the above student to any branch of the US Military.

Date: _____

Signature: _____

Four Corners Youth Clinics

every child PEDIATRICS

General Information

Mission: Keep children and youth healthy, in school, and ready to learn.

Vision: All students have a right to access quality integrated health care in a caring and supportive environment that optimizes education, health, and well-being.

Facts:

- Services are available to all students in Montezuma County.
- For medical health services, insurance is accepted (Medicaid, CHP+ and private insurance).
- A sliding scale applies for uninsured patients.
- For behavioral health services, uninsured and private insured patients will be placed on a sliding fee scale.
- Additional charges might apply for laboratory tests.
- Each month, a patient statement indicating full charges, discounts and balance will be mailed to the home address.
- **No one will be turned away due to inability to pay.**
- Appointments are preferred, but walk-ins are accepted (when available).

To Make Appointments:

- Southwest Open School campus: Please call 970-560-5056
- Dolores School District campus: Please call 970-560-4890

Registration forms may be dropped off at the clinics, emailed to 4CYC@everychildpediatrics.org, or faxed to 970-564-1654 (Cortez) or 970-459-3120 (Dolores).

Staff:

- Michelle Rhonehouse, FNP - Nurse Practitioner
- Patricia Nelson, LPC – Behavioral Health Provider
- Eli Cover, LPC – Behavioral Health Provider
- Julie Hite, RN – Registered Nurse
- Karen Ragland – Medical Receptionist/LPN - SWOS
- Amy Gordanier – Medical Receptionist – SWOS
- Debra Frans – Medical Receptionist – Dolores
- Sarah Jones – Program Manager

Typical Conditions Seen at the School-Based Health Center:

- Colds, flu, sore throats
- Stomach upset- nausea, vomiting, diarrhea longer than 24 hours
- Recurrent headaches
- Muscle sprains, joint pains
- Well child exams
- Skin problems and rashes
- Nutrition
- Sports physicals
- Follow up and monitoring of chronic medical conditions like diabetes and asthma in conjunction with patient's family physician
- Menstrual disorders
- Urinary tract infections
- Health questions and personal health education
- Mental health assessments and therapy
- Dental services (including education, screening, and appropriate referrals for dental care)

Reviewed 2/23/23

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Four Corners Youth Clinics

every child PEDIATRICS

Registration Form

Services include: ● Primary Care ● Physical Exams ● Immunizations ● Dental Clinics ● Behavioral Health Services

Legal Patient Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Legal Sex:** ☐ M ☐ F **Gender Identity:** _____ **Pronouns:**_____

School Attending: _____ **Grade Level:** _____ **Patient Email:**_____

Patient Cell Phone #: _____ **Permission to Call/Text:** ☐ Yes ☐ No

Race: ☐ Hispanic ☐ Asian ☐ Black or African American

☐ White ☐ Native American ☐ Hawaiian/Pacific Islander ☐ Other or Undetermined

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Address: _____ **Zip:** _____

Parent/Guardian Name: _____ **Phone #:** _____

Parent/Guardian Email: _____ **Permission to Call/Text**: ☐ Yes ☐ No

Family Information

Parent/Guardian #1 Name: _____ **DOB**:_____ **Relationship**: _____ **Phone #:**_____
(With whom the child lives)

Parent/Guardian #2 Name: _____ **DOB**:_____ **Relationship**: _____ **Phone #:**_____
(With whom the child lives)

Address: _____ **Apt #** _____ **City:** _____ **County:** _____ **Zip Code:**_____

Emergency Contact: _____ **Relationship:** _____**Phone #:** _____
(Aside from those that live with child (patient) at home)

Health Insurance: ☐ None ☐ Private ☐ Medicaid ☐ CHP+ ☐ IHS

Insurance Co. Name:_____ **ID #**:_____ **Group #:** _____

Primary Provider: _____

FOR MEDICAL SERVICES - MUST SHOW INSURANCE CARD AT TIME OF VISIT OR SIGN INCOME ATTESTATION FORM FOR SLIDING FEE SCALE.

FOR BEHAVIORAL HEALTH SERVICES – UNINSURED AND PRIVATE INSURED PATIENTS WILL BE PLACED ON A SLIDING FEE SCALE.

PRINTED name of parent/guardian:_____

SIGNATURE of parent/guardian: _____ **Date:** _____

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History Form

Legal Patient Name:_____ **Date of Birth**:_____ **Legal Gender**:_____

Current Medications: ☐ None ☐ Yes _____

Allergies (medications/food/insects): ☐ None ☐ Yes _____

Have you <u>ever</u> had or experienced *(Check all that apply)*:

☐ Arthritis	☐ Asthma	☐ Anemia	☐ Diabetes	☐ Mono
☐ Heart Problems/Murmur	☐ High Blood Pressure	☐ Kawasaki Disease	☐ Sickle Cell	☐ Seizure
☐ Skin rash or infections	☐ Stress fracture	☐ Broken bone	☐ Eye injury	☐ X-Ray
☐ Torn ligament/tendon	☐ MRI/CAT Scan	☐ Bulge or pain in groin area	☐ Surgery	
☐ Head Injury or Concussion	☐ Dislocated joint	☐ Spent night in hospital	☐ Wear glasses/contacts	

Where were you born?_____

At birth, were you born: ☐ Premature ☐ Missing any organs ☐ Heart problems/surgery as a baby

When you exercise, have you ever:

Passed out or nearly passed out? ☐ Yes ☐ No
Had any discomfort, pain, heaviness or tightness in your chest? ☐ Yes ☐ No
Cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No
Felt your heart race or skip beats? ☐ Yes ☐ No
Get shorter of breath than expected? ☐ Yes ☐ No
Have any joints that become red, swollen, or painful? ☐ Yes ☐ No
Any bones, muscles, or joints that bother you? ☐ Yes ☐ No
Have you ever used an inhaler? ☐ Yes ☐ No
Had headaches? ☐ Yes ☐ No
Had numbness, tingling, or weakness in arms or legs? ☐ Yes ☐ No
Become ill when exercising in the heat? ☐ Yes ☐ No
Regularly use a brace or other device? ☐ Yes ☐ No

Do you worry about your weight? ☐ Yes ☐ No If yes, are you wanting to: ☐ Gain weight ☐ Lose weight
Any special diet or foods you avoid? _____

Girls: Have you ever had a menstrual period? ☐ Yes ☐ No If yes, how old were you when you started?_____

Family History: Does anyone in ***your family*** have: ☐ High Blood Pressure ☐ Severe allergies ☐ Asthma
☐ Sickle Cell ☐ Cancer ☐ Diabetes ☐ Seizures ☐ Heart Problems

Additional comments:_____

_____

Parent/guardian signature: _____ Date: _____

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Consent for Treatment

Parental Consent: I understand that my child may be seen at Four Corners Youth Clinics (4CYC) only with my consent if under 18 years of age or not emancipated, or able to provide minor consent in accordance with Colorado state law, and that this consent will remain in force through the age of 21 or until I revoke said consent in writing. It is my responsibility to notify the clinic about changes in guardianship or insurance. The only exceptions to this policy are: a student may be seen one time to discuss the need for services; services will be provided in case of any emergency.

Release of Information: 4CYC is a HIPAA compliant school-based health center. Information in my child's healthcare record is confidential and will not be released to any unauthorized person or agency without written consent. In conformance with Colorado law guiding all medical facilities, my son/daughter may request that visits and health information remain confidential, under some circumstances. For me or any other party to have access to healthcare records regarding such information, my child must complete a written release.

Data Sharing Information: I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for health services I/my child receives at this school-based health center and is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients, and this data does not specifically identify any individual patient.

Coordination of Care/Billing: I authorize 4CYC to disclose all or any portion of my child's healthcare record to any person or entity performing record keeping or billing services for the 4CYC and any person or entities performing billing on behalf of 4CYC. I give consent to the 4CYC staff to review my child's school records, attendance, and other records that may assist 4CYC providers to help my child. I also authorize the staff of 4CYC to disclose all or any portion of my child's medical record to persons or entities pertinent to his/her health care, including his/her primary care provider, school nurse or school health paraprofessionals, mental health providers, Every Child Pediatrics staff, the Food Service Director, the Montezuma County Public Health Department, and/or employees of the Dolores School District RE-4A/Montezuma-Cortez School District RE-1 who, as determined by 4CYC, are closely involved with monitoring my child's welfare and have a reasonable need to know such information. I understand that if my child is scheduled for an overnight school trip, basic medical information such as allergies, immunization status, past medical history, and current meds may be shared with the supervising teacher to provide for a safe and healthy environment during the trip. I also give consent to access my child's school immunization information and for it to be entered into the Colorado Immunization Information System (CIIS).

I give my consent for named patient to receive necessary and/or advisable health services from staff of 4CYC.

☐ **I acknowledge receipt of the Notice of Privacy Practices and Patient Bill of Rights and Responsibilities:**

Patient Name:_____

PRINTED name of parent/guardian:_____

SIGNATURE of parent/guardian: _____**Date:** _____

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Income Attestation for Sliding Fee Scale

Legal Patient Name:_____ Date of Birth:_____

If your child wishes to receive services from Four Corners Youth Clinics and does not have health insurance, or if for some reason you do not wish to bill your health insurance carrier, you must answer the questions below to qualify for our sliding fee scale.

1. How many people live in your household? (Circle one)

   1 2 3 4 5 6 7 8 9 10 or more

2. Roughly, what is your family's gross total income per year, before taxes?

   $_____/Year

I certify that the above family financial information is true and accurate to the best of my knowledge. I understand that this information needs to be updated yearly, and I will be asked to sign this form at such time. You may also update this form as your income changes at any time.

Behavioral health services are limited to billing Medicaid and United Health/RMHP at this time. All other rendered services for behavioral health will need to be on a sliding fee scale for uninsured patients and patients with private insurance coverage. Payment is collected at the time of the appointment.

Parent/Guardian Signature:_____ Date:_____

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Notice of Privacy Practices for Protected Health Information

This school-based health center is permitted by federal privacy laws to make uses and disclosures of your protected health information for the purposes of treatment, payment, and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

TREATMENT: We will use and disclose your protected information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, if, during the course of your treatment, the physician determines he/she will need to consult with a specialist, he/she will share the information with such specialist and obtain his/her input.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. If the health insurance company requests information from us regarding your care, we will provide that information to them.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services and insurance. We will share information about you with such business associates as necessary to obtain these services; or a school nurse, school health paraprofessional or daycare provider to assure children attend school in a healthy state.

We may use or disclose, as needed, your protected health information in the following situations without your authorization. These situations include: as Required by Law, Communicable Disease, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of Every Child Pediatrics. The information in it, however, belongs to you. You have the following right:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this

Reviewed 2/24/23

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Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you, by mail, of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected information. If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature: _____

Date: _____ Patient Name: _____ DOB: _____

Patient Notification of the Use of Health Information Exchange

Every Child Pediatrics endorses, supports, and participates in the electronic Health Information Exchange (HIE) as a means to improve the quality of your child's health and healthcare experience. HIE provides us with a way to securely and efficiently share your child's clinical information electronically with other physicians and healthcare providers that participate in the HIE network. Using HIE helps your child's healthcare providers to more effectively share information and provide your child with better care. The HIE also enables emergency medical personnel and other providers who are treating your child to have immediate access to their medical data that may be critical for their care. Making your child's health information available to their healthcare providers through the HIE can also reduce costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt out of, on behalf of your child, participation in Every Child Pediatrics HIE, or cancel an opt- out choice at any time.

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Patient Bill of Rights and Patient Responsibilities

Four Corners Youth Clinics support the rights of all patients. These rights may be exercised through the patient individually or through their surrogate decision-maker/legal representative.

You have the right to…

- Be informed of your patient rights in advance of receiving or discontinuing care.
- Have impartial access to care. No one is denied access to treatment because of disability, national origin, culture, age color, race, religion, gender identity, or sexual orientation. No one is denied treatment of an emergency medical condition because of their source of payment.
- Give informed consent for all treatment and procedures with an explanation in layman terms of:
  - **a.** Recommended treatment or procedure
  - **b.** Risks and benefits of the treatment or procedure
  - **c.** Likelihood of success, side effects and risks including death
  - **d.** Alternatives and consequences if treatment is declined
  - **e.** Explanation of the recovery period
- Participate in all areas of your care-plan, treatment, care decisions, and discharge plans.
- Have appropriate assessment and management of your plan.
- Be informed of your health status.
- Be treated with respect and dignity.
- Personal privacy, comfort and security to the extent possible during your time at the clinic.
- Be free from seclusion or restraints.
- Confidentiality of all communication and clinical records related to your care.
- Have access to telephone calls.
- Have the right to choose a visitor who maybe with you during your visit as appropriate.
- Have access to interpreter services at no cost to you.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Have access to protective services.
- Request medically appropriate and necessary care.
- Refuse any drug, test, procedure, or treatment and be informed of the medical consequences of such a decision.
- Consent or refuse to participate in any study, trial, research program.
- Receive information about Advance Directives per request.
- Participate in decision-making regarding ethical issues, personal values or beliefs.
- Have access to your clinical records within a reasonable timeframe.

Patient Responsibilities:

- Ask questions and promptly voice concerns.
- Give full and accurate information as it relates to your health, including medications.
- Report changes in your condition or symptoms, including pain and request assistance of a member of the health team.
- Participate in the planning of your care, including discharge planning.
- Follow your recommended treatment plan.
- Be considerate of other patients and staff.
- Secure your valuables.
- Follow facility rules and regulations.
- Respect property that belongs to the clinic.
- Understand and honor financial obligations related to your care, including understanding your own health insurance.

Note: A copy of this document can be provided to you at the time of your appointment if requested.

Reviewed 2/24/23

Authorization for Disclosure of Protected Health Information

Four Corners Youth Clinics keeps medical records confidential. In order to provide the best health care for your child, we request your permission to release prior records to our clinic.

Patient Name:_____**DOB**:_____

Name of Person(s)/Organization for Exchange of Information From:

1. **Name**:_____**Phone**:_____

   Address:_____

2. **Name**:_____**Phone**:_____

   Address:_____

Release to:
Four Corners Youth Clinics - Cortez
P.O. Box 1701, Cortez, CO 81321
Ph: (970) 560-5056 Fax: (844) 819-9153

Information to be Released:

☐ Primary Care Record ☐ Behavioral Health Record ☐ Labs ☐ Immunization Record
☐ ER Report ☐ Reproductive Health ☐ Surgical Record ☐ Discharge Summary
☐ Consultations ☐ Entire Record ☐ Other:_____
Specific Dates:_____

Reason for Disclosure:

☐ Physician Change ☐ Insurance ☐ Other:_____

I certify that this request has been made voluntarily and that the information above is accurate. Disclosure of information between entities will follow minimum guidelines necessary. I understand that this consent may be revoked at any time, in writing, with the exception that disclosure of information has already occurred prior to the receipt of the revocation by the above-named provider. This authorization will be considered valid for one (1) year not to exceed 365 days from the date of signing.

Individual Patient's signature: I have read and agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the PHI described in this form with the people and/or organization named in this form.

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

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

Relationship to Patient:_____

Student Signature:_____**Date**:_____

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Southwest Open School
School Nurse Health Consent

Student's Full Name:_____**Legal Sex**:_____**Date of Birth**: _____

Name and Phone # of person to contact regarding medical questions or concerns:

Name:_____**Phone:** _____

Four Corners Youth Clinics, located on the SWOS campus, provides **school nurse services to SWOS students.** *This is separate from the full school-based health services. If you would like your student to utilize all school-based health services, please fill out the "Consent for Treatment" form included in the enrollment packet.*

The school nurse may administer the following **"over the counter" medications**, but this action **requires your signed consent**. Below are the medications available. Please mark an **"X"** through medications you do not want administered:

☐ Tylenol/Acetaminophen ☐ Motrin/Ibuprofen ☐ Midol ☐ Suphedrine (decongestant)

☐ Zyrtec/Cetirizine ☐ Claritin/Loratadine ☐ Benadryl ☐ Guaifenesin (cough medicine)

☐ Anti-diarrheal ☐ Tums ☐ Antibiotic Ointment ☐ Cough Drops ☐ Hydrocortisone Ointment

I give my permission for my student to be given the listed medications in the age appropriate dosage, per package instructions, during the school day when appropriate after nursing assessment.

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

Health Care Plans are needed for students with **asthma, allergies requiring EpiPen injections, diabetes and seizures**. These must be filled out and signed by your healthcare provider or with consent through the Four Corners Youth Clinics and will be shared with school staff.

Immunization Registry Notice: Your child's immunization record is being entered in the Colorado Immunization Information System (CIIS), a confidential, statewide immunization tracking system unless you choose to exclude your child's record. If you wish your child exempt from immunizations, you must complete the form annually. Please speak with the nurse if you have any questions.

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