APPLICATION: PARENT STATEMENT

This portion of the application is to be completed by the parent or guardian of the applicant. Please include a non-refundable $35.00 application fee made payable to Colorado Timberline Academy.

Father's Full Name _____

Home Address _____

_____

Phone Number_____ EmailAddress_____

Profession _____ Cell Phone # _____

Office Address _____

Phone Number_____ FAX Number _____

Mother's Full Name _____

Home Address (if different from above)

_____

_____

Phone Number_____ Email Address _____

Profession _____ Cell Phone # _____

Office Address _____

Phone Number_____ FAX Number _____

Has your child ever seen a professional counselor, either educational or psychological? Yes No

Describe the circumstances in full, and give the name and address of the counselor.

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPLICATION: PARENT STATEMENT

1. I agree to meet the financial obligations outlined by the current Fee Agreement.

2. Having read the rules, I am in accord with the philosophy and ideals of the Colorado Timberline Academy and pledge my support to the faculty in implementing the program.

3. I will provide full disclosure of any and all pertinent physical, academic or emotional needs or special problems which may have prompted my child's application or may impact on their behavior at Colorado Timberline Academy.

4. If my child is put on any prescription medication during the academic year, I will immediately notify the school.

5. I understand that Colorado Timberline Academy requires all students to carry health insurance and or standard student accident insurance. My child is covered by policy number_____ with (Company) _____
Phone #_____
(address)_____

6. I understand that Colorado Timberline Academy will try to contact me by telephone in case of medical emergency for my child. **However, in case I cannot be reached by telephone, I hereby delegate to the director, or his designated representative, the authority to authorize and consent to any and all medical, surgical, dental or hospital care or treatment for my child while a student at Colorado Timberline Academy.** Such treatment is to be rendered only by a duly licensed physician or dentist. The faculty is fully authorized to act in accordance with their own judgment in any such emergency and are absolved from any liability or financial responsibility in connection therewith.

_____ _____

Parent or Guardian Signature Date

APPLICATION: PARENT STATEMENT

MEDICATION AND ALLERGY INFORMATION

To be completed by the parent or guardian:

NAME OF STUDENT _____

ALLERGIES TO MEDICATION? _____

ALLERGIES TO FOOD? _____

MEDICATION(s)_____

DOSAGE_____

PURPOSE OF MEDICATION_____

POSSIBLE SIDE EFFECTS_____

ANTICIPATED LENGTH OF TIME THIS MEDICATION WILL NEED TO BE GIVEN AT SCHOOL

_____

DATE_____

I HEREBY GIVE MY PERMISSION FOR_____
TO TAKE THE ABOVE PRESCRIPTION AT SCHOOL AS ORDERED. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO FURNISH THIS MEDICATION AND MY CHILD'S

RESPONSIBILITY TO TAKE THE MEDICATION AS PRESCRIBED. ALL PRESCRIPTION MEDICATION MUST BE GIVEN TO THE COUNSELOR. IT MAY NOT BE KEPT IN THE STUDENT'S ROOM.

I AUTHORIZE ATTENDING PHYSICIANS TO DISCUSS AND/OR RELEASE ANY AND ALL MEDICAL INFORMATION CONCERNING MY CHILD. _____

Signature of parent or legal guardian _____

DATE _____

Name & Phone # of Emergency Contact _____

NOTE: THE PRESCRIPTION MEDICATION IS TO BE BROUGHT TO SCHOOL IN A CONTAINER APPROPRIATELY LABELED BY THE PHARMACY OR PHYSICIAN STATING THE NAME OF THE MEDICATION AND DOSAGE. STUDENTS ARE REQUIRED TO GIVE ALL PRESCRIPTION MEDICATION TO THE COUNSELOR. THESE MEDICATIONS MAY NOT BE KEPT IN THE STUDENT'S ROOM.