Longview School
at the Summit Center
an RSEC Program

Student's Release Packet

The Longview School is committed to providing students with an educational opportunity which strives to address individual special needs. We are committed to offering a safe environment, built on respect and tolerance, cooperation and communication.

When becoming a Longview student, you commit to keeping a positive attitude within the community, while respecting the diversity of others. You must be willing to challenge yourself mentally, physically and emotionally.

Requirements for the Longview student:

1. Awareness of one's issues.
2. An ability to have self control and a willingness to work on personal issues.
3. Demonstration of progress and growth in the identified areas by putting into action newly acquired skills and strategies.

(Awareness/Acceptance/Actions)

Prior to acceptance, each student will identify a personal goal based on an identified area of concern upon intake. During your 45-day assessment period, staff will work with you to modify your goal(s) and identify new goals. It is important that you remain open to feedback and participate as a positive community member.

To be completed by the student:

1. I have completed the level of awareness survey and discussed it with a counselor. ( ) Please check.
2. My personal goal is:
   _____
   _____
3. Evidence that I am making progress in working on this goal would be:
   _____
   _____

I have read and understand the rules and expectations stated in the student handbook. I understand that failure to follow and make academic and social/emotional progress will impact my placement. I am committed to being at Longview School.

_____ _____

(Student Signature) (Date)

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PERMISSION FOR THE LONGVIEW SCHOOL TO EXCHANGE INFORMATION WITH A STUDENT'S SCHOOL DISTRICT

This permission is a prerequisite for enrollment at the Longview School

Name of student: _____ Date of Birth: _____

Name of adult signing on minor student's behalf: _____
[please print]

Adult's relationship to student: _____

I hereby give permission for all of the following:

1. For the Longview School to disclose any and all records regarding the student to the following school district:

_____

2. For that school district to disclose any and all records regarding the student to the Longview School.

3. For the Longview School and that school district to orally disclose to each other information regarding the student, including but not limited to information from records.

These permissions are for the purpose of processing the student's application for admission to the Longview School, for the Longview School and the school district to provide the student with an appropriate education, and to facilitate communication between the Longview School and the student's school district.

A copy of this permission shall have the same force as the original.

I understand that pursuant to U.S. Public Law 93-380, the Family Educational Rights and Privacy Act of 1974 (FERPA), the Longview School will not disclose education records (or personally identifiable information in those records) without prior written consent from the student's parent (or from the student if the student is an adult), subject to the exceptions set forth in that law. Such written consent must specify the records to be disclosed, the reason for disclosure, and to whom the records may be disclosed,

Signature: _____ Date: _____
Parent, Legal Guardian, or Adult Student (age 18 or over)

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an RSEC Program

PERMISSION TO DISCLOSE RECORDS (HIPAA-COMPLIANT)

Check appropriate box:

□ I, _____, an adult student (age 18 or older) (DOB _____),
□ I, _____, parent/ legal guardian of _____, a minor student (DOB _____), hereby authorize:_____,
hereafter referred to as "provider(s)," to disclose all records and information in their possession regarding the student to the Longview School. The Longview School's mailing address is PO Box 369, Deerfield, NH, 03037.

This authorization allows the above provider(s) to copy and send records to the Longview School and allows representatives of the Longview School to inspect the records. This authorization also allows the above provider(s) to orally disclose information to the Longview School, including but not limited to information contained in records.

This authorization encompasses *all* records pertaining to the student, including but not limited to correspondence, notes, reports, questionnaires, application forms, contracts, billing records, payment records, insurance records, work samples, discipline records, report cards, teacher grade books (with other students' names redacted), test protocols (questions and answers), test score calculations, any other test records, medical records, health records, counseling records, mental health records, computer data, *and "third party records"* created by any other individuals or organizations. The term "records" includes information recorded, maintained or preserved in *any* medium, including but not limited to printed, handwritten, magnetic, or electronic.

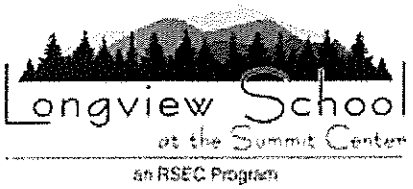
I specifically authorize the release of HIV/AIDS results and/or treatment, where applicable.
I specifically authorize the release of psychiatric records, where applicable.
I specifically authorize the release of alcohol and substance abuse treatment records, where applicable.

Any costs for photocopying these records for the Longview School, or for mailing these records to the Longview School, shall be at the Longview School's expense.

Pursuant to HIPAA, the following are specified as part of this authorization:

a. The purpose of disclosure is to help the Longview School identify the student's needs and provide appropriate educational services.
b. This authorization expires one year after the date it is signed.
c. The person signing this form understands that he or she may revoke this authorization at any time by providing written notification to the Longview School or to the provider(s) named above, except to the extent that this authorization has already been relied on.
d. The person signing this form has been informed that the provider(s) named above may not condition treatment, payment, enrollment, or eligibility for benefits on whether that person signs this authorization.
e. The person signing this form has been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. However, the federal Family Educational Rights and Privacy Act (FERPA) generally prohibit the Longview School and its employees and agents from disclosing student records (or information from those records) without prior written parental consent.

Date: _____ By:_____
Adult Student/Parent/Legal Guardian



PERMISSION TO DISCLOSE RECORDS

(FERPA-COMPLAINT)

Check appropriate box:

☐ I, _____, parent and/or legal guardian of

_____, a minor (DOB _____),

☐ I, _____, an adult student (age 18 or older)

(DOB _____),hereby authorize the Longview School to disclose records

(and personally identifiable information from those records) to:

_____

(Recipient's Name and Address)

This authorization pertains to the following categories of records [check one box]:

☐ All records

☐ Specify:_____

_____

The purpose of this disclosure is: _____

_____

_____

Date:_____ By:_____

Student/Parent/ Legal Guardian

RELEASE OF INFORMATION

Student Name: _____

Street Address: _____

City: _____ State: _____ Zip Code:_____

Social Security # _____

We/I _____give permission to obtain or release necessary health, academic, psychological and relevant background information (for example: residential placements, court involvement, history of violent behaviors) on _____ for the purpose of referral to the Longview School.
(student name)

This information will be held confidential and will be used only for the benefit of the student.

_____ _____
(Signature of Parent/Guardian) (Date)

_____(Relationship to Student)

The Longview School 55 Reservation Road/PO Box 369 Deerfield, NH 03037 Phone 603-463-7854 Fax 603-463-7867 Email longview@rsec.org

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RELEASE AND ASSUMPTION OF RISK

Student Name: _____ Date: _____

I am aware of that participation in the RSEC / LONGVIEW School Adventure Based Program involves certain risks, including, though not exclusively, the hazards of travel in mountains, rivers and other remote areas, without communication or medical facilities, and subject to the unpredictable forces of nature. I/we understand that the school cannot guarantee the safety of students, but rather that it is the school's obligation to take due care and exercise reasonable precautions for the safety and well-being of students. My/our child also has the responsibility for his/her safety and the safety of others. Knowing of such inherent risks and dangers, and in consideration of the right to participate in the program, I represent and agree as follows:

1. I am fully capable of participation in said program without causing risk of danger, illness, or accident to myself or others.
2. I assume all risks associated with the program. I agree that I will not make any claim or sue for any injury or damage which may arise out of my participation in the program, including injury or damage which may result from the acts - negligent or otherwise - of the Regional Services and Education Center, The Longview School, or any agent, employee, or contractor of the Regional Services and Education Center (including other participants in program).
3. I release and agree to hold harmless the Regional Services and Education Center, Longview School, it's agents, employees and contractors, from any liability for injury or damage which I may suffer or incur, arising out of my participation in the Adventure Based Program.

I have carefully read this agreement and understand it's contents, and I sign it of my own free will. I am aware that this is a Release of Liability, including liability for negligence, and is a binding contract between the Regional Services and Education Center, The Longview School, it's agents, employees and contractors, and myself, and it likewise shall be binding on my heirs, executors, administrators, and assignee, and on any member of my family for whom I sign. References to "I" shall include any such family member.

_____ _____
(Signature of Participant) (Date)

_____ _____
(Signature of Parent/Guardian) (Date)

_____(Relationship to Student)

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INFORMED *CONSENT*

Privacy of Information Shared in Counseling:
Your Rights and My Policies

What to expect
The purpose of meeting with a counselor is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and guide you in the development of a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

Confidentiality
As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a counseling session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below:

Confidentiality cannot be maintained when:
a. When a parent of a minor child requests information.
b. When abuse or neglect is suspected.
c. When the individual is seen as a threat to themselves or others, or property of others.
d. When ordered by a court

Communication between Longview School staff members:
Students will be assigned to a primary counselor, however treatment is provided within a treatment team in order to best meet the needs of the student. Within the course of treatment, a student's information may need to be reviewed by the treatment team, which includes all school employees and outside contracted supervisors. All members of the treatment team are legally bound to the confidentiality laws explained above. By signing this document you are acknowledging that you understand that I may discuss your case in consultation and/or supervision.

Communicating with your parent(s) or guardian(s):
Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of

being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

Communicating with other adults:
There may be times when I need to share information with other adults in your life that are working with you; this may include another counselor or doctor. Before sharing any information I will get written permission from you and your parent/guardian.

Records:
A record of your contacts and treatment with the Longview School will be kept for 7 years starting on the day you are no longer a student here. You may request to review your records or receive a copy of your records. Records will be released within 30 days of receiving written request by the owner of the record.

Client Consent
By signing this form, I acknowledge that I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to engaging in treatment at the Longview School.

Student's Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Longview Counselor_____ Date_____

PHYSICAL FORM

Please have your physician complete this from and return to Longview School.

Student Name _____ Date _____

Within the Adventure Based Counseling component at the Longview School the above named student will take part in a variety of activities over the school year. These activities include, but are not limited to: backpacking, mountain biking, cross country skiing, snowshoeing, white water canoeing, downhill skiing, and rock climbing.

This student is able to participate in a physically demanding program during the 2013-2014 school year with no limitation. His/her last physical was on _____.

Are immunizations are up to date? Yes / No

Please include a copy of immunization records for student file.

Last tetanus given _____

_____ _____

Physician Signature Date

_____

Physicians Name (Please Print)

_____

Address

_____

City, State Zip

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STUDENT EMERGENCY AUTHORIZATION FORM

THIS FORM MUST BE COMPLETED IN FULL BEFORE A STUDENT IS PERMITTED TO ATTEND LONGVIEW

Student Name: _____ DOB: _____ Age: ____ Place of Birth: _____

Social Security Number: _____-_____-_____ M__ F__ Height: _____ Weight: _____

Student resides with *: Name (s) _____Relationship: _____

Address: _____

Town: _____Zip Code: _____

*Father's Name: _____ Place of Employment:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email:_____

*Mother's Name: _____ Place of Employment: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email:_____

Parental Marital Status: Married ( ) Divorced ( ) Separated ( ) Other (explain): _____

Student Lives With: _____

*If student does not reside with both parents, a court decree, or legal agreement establishing custody, must be on file for the child to enter/continue school.

Sending School: _____ Grade: _____

EMERGENCY CONTACTS: May be required to transport student in event of illness or evacuation.

Please provide two emergency contacts in case of illness or injury if you cannot be reached:

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Student Physician:

___ _____ Address _____ Town _____ State _____Phone

Student Dentist:

___ _____ Address _____ Town _____ State _____Phone

Is student covered by a hospitalization and medical care policy? Yes ____ No _____

Name and Address of Insurance Company:

_____

_____

Policy and Identification Number: _____

MEDICAL INFORMATION

Pain relievers (Tylenol/motrin/asprin) may be given: ___Yes ___No

PLEASE BRING IN A BOTTLE OF PAIN RELIEVER TO SCHOOL.

Student wears glasses?___Yes ___No Student wears contact lenses? ___Yes ___No

Antacids may be given? ___Yes ___No

Benadryl may be given? (Used as a safety protocol to any student who is stung by a bee or if the insect can't be determined)? ___Yes ___No

Allergies? ___Yes ___No (If yes, please specify ie. food, plant, animal, insect, medicine, etc.)

_____

_____

_____

Special Dietary Restrictions? _____

Date of most recent DPT(Diphtheria/Tetanus) Immunization Booster: _____

Medication(s) taken regularly (please specify purpose):

_____

_____

_____

Other medical problem(s): please specify:

_____

_____

_____

_____

MEDICAL HISTORY:

The Longview School Adventure Based Counseling Program conducts its activities outdoors. Weather conditions can be extreme with temperatures ranging from below zero to 90+. High winds, storms, and a variety of weather conditions are possible. Participants will sleep outdoors and often carry heavy packs while on trips. They will climb and descend from rock faces and trees, canoe all types of water, ski uphill and downhill, mountain bike for extended periods of time over hilly terrain, and walk and run short and/or long distances. The program is physically demanding. **Please take time to fill out this form carefully.**

Does the applicant currently have or have a history of any of the following (CHECK and explain below if yes):

Epilepsy	Arthritis	Cardiac problems
Respiratory problems	Neurological problems	Diabetes
Gastrointestinal disturbances	Bleeding disorders	Back problems
Hypertension	Frostbite	Liver dysfunction
Eating disorders	Thyroid problems	Urinary tract disorders
Menstrual/abdominal problems	Knee or ankle problems	Joint problems

_____

_____

Drug/Alcohol/Chemical Abuse or Dependency?

_____

_____

Are a counselor, psychologist and/or psychiatrist currently treating the student? Yes: ___ No: ___

If yes indicate name(s) and phone number(s):

_____

Other Problems or Considerations:

_____

_____

As a parent or guardian I fully understand the rigorous nature of the LONGVIEW SCHOOL ADVENTURE BASED COUNSELING PROGRAM. In the event of an emergency, I give my permission for any operation and/or anesthesia, which might become necessary. In case of medical emergency, in the event that I/we cannot be reached, I/we authorize Longview School, it's agents, employees, or other officers to procure and consent to any medical examination, diagnostic process or course of treatment, including transportation and hospital care, to

be rendered to my/our child by or under the supervision of any duly licensed health care provider. **A copy of this authorization is to be accepted as valid as the original.**

I also agree to provide, **by the starting date of the program**, a note from a physician stating that my child is free to participate in a physically demanding program.

Parent/Guardian Signature _____ Date_____

_____(Relationship to Student)

NOTE TO PARENT/GUARDIAN: It is important that the parent/legal guardian notify the principal of any modifications to the above information.

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CONCUSSION AND HEAD INJURY INFORMATION SHEET

A concussion is a brain injury caused by a blow or a motion to the head or body, which causes the brain to move rapidly inside the skull. A concussion can range from mild to severe and can disrupt the way the brain normally works. A concussion can occur during practice or games in any sport or recreational activity. You do not have to lose consciousness to have a concussion. The risk of catastrophic injuries or death is significant when a concussion or head injury is not properly evaluated and managed.

You cannot see a concussion. The signs and symptoms of a concussion may appear immediately or they may not appear until days after the injury. If your child reports any symptoms of a concussion, or if you notice the symptoms or signs of a concussion, seek medical attention.

Symptoms Reported by Student Athletes	Signs Observed by Parents or Guardians
Headache	Loss of consciousness
Nausea	Appears dazed
Balance Problems or Dizziness	Confused about assignment or position
Blurred, double or fuzzy vision	Forgets an instruction
Sensitivity to light or noise	Is unsure or the game, score or opponent
Fogginess or grogginess	Clumsiness
Drowsiness or sluggishness	Answers questions slowly, slurred speech
Concentration or memory problems	Behavior or personality changes
Confusion	Can't recall events *prior* to the injury
Change in Sleep Patterns	Can't recall events *after* the injury
Depression or anxiety	Seizures or convulsions

Continuing to participate in physical activities with the signs/symptoms of a concussion leaves the student vulnerable to greater injury. Returning to participate in physical activities before completely recovering from a concussion increases the likelihood of sustaining another concussion. A repeat concussion that occurs before the brain recovers from the first can slow recovery and/or increase the likelihood of long-term problems. In some cases repeat concussions can lead to swelling of the brain, brain damage, and even death.

Source: Center for Disease Control and Prevention. For more information see: www.cdc.gov/Concussion

Parents and students are encouraged to read and acknowledge receipt of RSEC's Concussions and Head Injuries Policy and Procedures, which contains important information about removal from physical activities for suspected concussions or head injuries and return to participate in physical activities requirements.

A PARENT/LEGAL GUARDIAN AND STUDENT MUST SIGN THIS ACKNOWLEDGMENT:

1) BEFORE THE STUDENT WILL BE ALLOWED TO PARTICIPATE IN SCHOOL RELATED PHYSICAL ACTIVTIIES, AND

2) BEFORE BEING ALLOWED TO RETURN TO PARTICIPATE IN SCHOOL RELATED PHYSICAL ACTIVITIES AFTER A SUSPECTED CONCUSSION OR HEAD INJURY.

Parent/Legal Guardian and Student Acknowledgment

_____	_____	_____
Name of Student/Adult Student (printed)	Signature of Student/Adult Student	Date
_____	_____	_____
Parent/Guardian (printed)	Parent/Guardian	Date

Handbook Acknowledgment

Contained within the pages of the Longview School Handbook are general policies adopted by and adhered to at our school. This handbook is not intended to cover every incident. Longview Administration reserves the right to make decisions in an effort to maintain a positive learning environment through mutual respect and effective communication. These policies form the basis of the agreement parents/guardians and students make when choosing Longview School.

Please review the contents of this handbook with your child then complete the signature form below.

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

- **Please sign and date the attached Handbook Acknowledgment Page and return to the Administration Office at Longview School.**

- **A copy will be provided for your records if requested.**

Regional Services and Education Center, Inc. (RSEC)
94 Rt. 101A P.O. Box 370
Amherst, NH 03031-0370
Telephone (603) 886-8500 Fax (603) 886-0163

Photography and/or Audio Visual Consent

RSEC requires the written consent of the child's/student's parent/guardian or the adult student before a child/student/adult student may be photographed or recorded (either auditory or visual).

Child's (Student's) Name:_____ DOB:_____

I,_____, give my permission to allow Regional Services and Education Center, Inc. (RSEC) to do the following:

_____ Take and use photos/recordings (auditory or visual) for education purposes

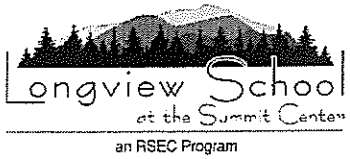
_____ Take and use photos/recordings (auditory or visual) for publicity

_____ Take and use photos/recordings (auditory or visual) for publication on RSEC's web site

Parents/guardians/adult students may refuse release of any or all use of these materials related to specific students provided that a written request is received by the program Director/designee or the Executive Director of RSEC.

Signature:_____ Date:_____
(Parent, Guardian/Legal Representative/Adult Student)

A copy of this Consent shall have the same force as the original.



EQUIPMENT AND VIDEO/PHOTOGRAPHY/AUDIO RELEASE

Student Name: _____ Date: _____

I understand that during my participation in the Longview School I will be responsible for the prudent use of equipment including but not limited to a computer, backpacking equipment, clothing, and mountain bikes; and I agree to be held financially liable for damage to or loss of such equipment.

This understanding also extends to my portion of any financial liability that the group of participants may incur as a group for damage to or loss of equipment.

I agree that my graduation from the program will be contingent upon any financial liability that I may incur to The Longview School due to the damage or loss of equipment as stated in the above paragraph.

I have carefully read this document and understand and agree to its contents, and I sign it of my own free will. I am aware that as the parent or legal guardian I will be held legally and financially responsible for damage to or loss of equipment as stated in the first paragraph of this document.

A parent or legal guardian's signature is required if the participant is under 21 years of age.

_____ _____
(Signature of Participant) (Date)

_____ _____
(Signature of Parent/Guardian) (Date)

_____(Relationship to Student)

I agree to allow photographs and videotapes to be taken of myself for the purposes of slide and/or video presentations and/or print or publication.

I understand that the Longview School uses photography, audio, and audio-visual recording as an assessment tool within the program (examples include but are not limited to using an individual's image and the sound of their voice for training educators at conferences, workshops, and as a demonstration of effective teaching). Photographic, audio, or video recordings used for educational purposes include but are not limited to conference and informational presentations, educational presentations or courses, and educational videos posted online.

A parent or legal guardian's signature is required if the participant is under 21 years of age.

_____ _____
(Signature of Participant) (Date)

_____ _____
(Signature of Parent/Guardian) (Date)

The Longview School 55 Reservation Road/PO Box 369 Deerfield, NH 03037 Phone 603-463-7854 Fax 603-463-7867 Email longview@rsec.org

VERTICAL DREAMS, INC. ROCK GYM: INFORMED CONSENT AND RELEASE WAIVER

Part One: Acknowledgement of Risk, Release/Indemnification of all claims covenant not to sue
NOTICE: This is a legally binding agreement. By signing this agreement, you give up your right to bring court action to recover compensation or obtain any other remedy for any injury to your children or yourself or your property or for your death however caused arising out of use of the facilities of Vertical Dreams, Inc., now or any time in the future. The information contained throughout this agreement and especially in the "Acknowledgement of Risk" and "Release" and "Safety Contract" section is interchangeable for the climber and/or parent who wishes to sign-off herein as having informed consent to permit their minor child to use the facilities of Vertical Dreams, Inc. "I" or "myself" is also reasonably interchangeable with "my child" herein. Climbing is Dangerous (for anyone!!!)

Acknowledgement of Risk I hereby acknowledge and agree that the sport of rock climbing and the use of the facilities of Vertical Dreams, Inc. have inherent risks. I have full knowledge of the nature and extant of all the risks associated with rock climbing and the use of the climbing gym, including but not limited to:

1. All manner of injury resulting from falling off the climbing gym and hitting rock faces and/or projections, whether permanently or temporarily in place, or on the floor.
2. Rope abrasion, entanglement and other injuries resulting from activities on or near the climbing gym such as, but not limited to climbing, belaying, lowering on ropes, rescue systems, and other rope techniques.
3. Injuries resulting from fallen climbers or dropped items, such as, but not limited to, ropes, climbing hardware and or holds.
4. Cuts and abrasions resulting from skin contact with the climbing gym and or the gym's devices and or hardware.
5. Failure of ropes, slings, harnesses, climbing hardware, anchor points or any part of the climbing gym structure.

I further acknowledge that the above list is not exclusive of all the possible risks associated with the use of the climbing gym and that the above list in no way limits the extent or reach of the release and covenant not to sue.

Release/Indemnification and covenant not to sue in consideration of my use of the climbing gym, I, the undersigned user, agree to release and on behalf of myself, my heirs, representatives, executors, administrators and assigns **HEREBY DO RELEASE** Vertical Dreams, Inc., its officers, agents, sponsors, and employees from any cause of action, claims, demands, losses, or costs of any nature whatever arising out of any relating to my use of the climbing gym.

In consideration of my use of the facilities of Vertical Dreams, Inc., I, the undersigned user, agree to INDEMNIFY AND HOLD HARMLESS Vertical Dreams, Inc., its officers, agents and employees from any and all causes of action, claims, demands, losses, or costs of any nature whatever arising out of any way relating to my use of the climbing gym.

I hereby certify that I have full knowledge of the nature and extent of the risks inherent in the use of the climbing gym and that I am voluntarily assuming the risks. I understand that I will solely be responsible for any losses or damage, including death, I sustain while using the Vertical Dreams, Inc. climbing gym and that by this agreement, I am relieving Vertical Dreams, Inc. and/or its agents legal fees should I one day wish to seek legal action against them as a result of my use of the facilities.

I understand the above Release and Acknowledgement of risk, I further certify that I and/or my ward is in good health and have no physical limitations which would preclude safe use of the facilities.

By signing this release, I hereby certify that I have not taken any alcoholic beverage, illegal drugs, or prescriptive medications (which may affect my ability to climb, in any way) within 24 hours.

I have read and understand the Release and Acknowledgement of risk, I further certify that I and/or my ward is in good health and have no physical limitations which would preclude safe use of the facilities.

X dated this day _____/_____/_____(mm/dd/yy).

Legibly print name: X_____

Signed(Climber):X_____CLIMBER signature REQUIRED

Signed (PARENT): X_____: PARENT Signature REQUIRED HERE if climber is under 18!!!. I, as a parent or legal guardian of the above minor under 18 years of age, hereby have been informed as to the hazards of climbing and do hereby consent to all the terms and conditions set forth in this release form as hereby signed above.

Email Address (will only be used for our newsletter or to notify you about specials)

X_____

X_____**(Mailing Address)**

X_____**(CITY),** _____**(STATE),**_____**(ZIP)**

X_____/_____/_____ **Climber's Date of Birth** (mo/day/year)

X_____-_____-_____ **Climber's Phone Number**

Emergency Contact Information: In case of Emergency call this person:

X(Whom?)_____(Phone #?)_____-_____-_____

I, the undersigned user of Vertical Dreams, Inc. I agree to abide by, and to help encourage, the following safety policies:

1. All climbers must have signed released form on file at the front desk and, to gain access to the climbing gym, present necessary identification, if requested. Climbers must read and obey current "Gym Rules" revised and posted at the front desk.
2. **Climbers will tie directly into their harness with a figure 8 follow-through knot**
3. When bouldering keep feet three feet or lower from the ground. Use a spotter.
4. Climbers and belayers will use formal belay commands and safety checks
5. Instruction is to be done by Vertical Dreams, Inc. staff agents only. We teach in our gym.
6. **No loose chalk. Please use a chalk ball.**
7. **All climbers MUST have a waiver on file.**
8. Lead climbers must supply their own reasonable UIAA-approved rope. Approved climbing equipment only. You must also pass our safety check before you are allowed to lead in our gym.
9. All personal items must be stored in bins. Please help keep the floor and benches clear. Put your gear away!!
10. **Parents must complete and sign waiver forms for climbers under 18 years old.**
11. Shirts are mandatory.
12. Where judgment and logistical constraints permit, we will teach 13 and older to belay.
13. Route setting by approval of Vertical Dreams, Inc. Management Only.
14. Vertical Dreams, Inc. reserves the right to deny access to its facilities to any individual permanently or for a specified period for breach of contract of the safety policies, or for any conduct that is viewed as unsafe or inappropriate.
15. No one under 13 years of age will be allowed to belay unless specific permission is given by Vertical Dreams, Inc. or its agents.

EMERGENCY MEDICAL RELEASE FORM

Pats Peak Ski Area

The purpose of this form is to give permission to the Pats Peak Ski Patrol, any responding ambulance service and/or Concord Hospital to provide emergency treatment for your child in the event of an illness or an injury. In the event of a serious injury or illness, every attempt will be made to contact the legal guardian listed below at the phone number listed. Emergency medical treatment however, will not be delayed while trying to make this contact.

(We) (I) Hereby grant permission to _____
(Print name of the ADULT person who is present)

Group/Program Name: _____

to secure Emergency Medical Care as _____
(Print name of minor)

Address: _____

City/State/Zip: _____

may require, for a period from _____

to _____
(Include entire length of program)

In the event of multiple persons being given permission, on first line above, write: (Any person listed below)

Names of person(s) authorized:

_____
_____
_____
_____
_____
_____
_____

List any medication(s) the minor taking:

_____
_____
_____

Lift any allergies:

_____
_____
_____

I have read and understand the information on the emergency medical form. All the information I have provided is true and complete.

_____ _____
Signature of parent or legal guardian *Print name and relationship*

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other: _____

LEARN TO SKI AND RIDE PROGRAM/GROUP COORDINATOR:
KEEP THIS FORM WITH YOU IN THE EVENT OF AN EMERGENCY;
BRING THE FORM TO THE SKI PATROL OFFICE.

PATS PEAK

Today's Date ___/___/___

Seasonal ☐ Multiday ☐ Return Date ___/___/___

Equipment Rental & Liability Release Agreement

Please fill out completely and press firmly.

Rentals require a credit card or valid driver's license.

Name:_____
Last First M.I.

Group Name: (if applicable)_____

Street:_____

City:_____ State:_____ Zip:_____

Phone:(___)___-____-____ Email:_____

Weight:_____lbs. Height:_____ft. _____in. Age:_____ Shoe Size:_____

Skier Type

SKIERS ONLY FILL THIS SECTION OUT
(Please check only one)

☐ I I am a cautious skier and prefer a lighter ski binding release/retention setting.

☐ II I am a moderate skier and prefer an average ski binding release/retention setting.

☐ III I am an aggressive skier and prefer a higher ski binding release/retention setting.

PLEASE CHECK ALL BOXES THAT APPLY

Select Equipment

☐ Skis ☐ Premium Skis ☐ Boots ☐ Poles

☐ Snowboard ☐ Snow Blades ☐ Helmet ☐ Snowshoes

FOR SHOP USE ONLY

Issued By_____

Skis No._____ Ski Length_____

Boot Sole Length_____

Skier Code_____

Snowboard No._____

	Toe	Heel
L		
R		

Method of Payment
Cash CK GC
MC V AE TR

TOTAL

I, THE UNDERSIGNED, HAVE READ AND UNDERSTAND THE "ACKNOWLEDGEMENT OF PERSONAL INFORMATION & EQUIPMENT INSTRUCTIONS" AND "EQUIPMENT RENTAL AND LIABILITY RELEASE AGREEMENT" ON THE BACK OF THIS FORM.

User's Signature:_____ Date:___/___/___

Parent/Guardian: If equipment user is a minor, I verify that I am the parent or guardian of the minor. I have authority to enter into this Equipment Rental and Liability Release Agreement on behalf of the minor. I agree to be bound by its terms. I accept full responsibility for all medical expenses incurred as a result of the minor's use of this equipment and their use of Pats Peak Skiing, LLC's facilities, and I agree to indemnify and hold harmless the **PROVIDERS** from any claim brought by, or on behalf of, the minor.

Parent/Guardian's Signature:_____ Date:___/___/___

PLEASE NOTE - 1. Ski bindings have been adjusted for your weight and your ability and may not be readjusted by any other person except a rental technician.

2. Rental Shop closes 30 minutes after lifts close. Please return equipment immediately after your last run.

Acknowledgement of Personal Information & Equipment Instructions

I have accurately represented the requested personal information and it is true and correct. I will not use any of the equipment that is rented to me during this transaction until I have received instruction on its use and I fully understand its use and function. If I am renting downhill ski equipment I will verify that the visual indicator settings to be recorded on this form match the numbers appearing in the visual indicator windows of the rented downhill ski equipment bindings.

Equipment Rental & Liability Release Agreement

I accept for use **AS IS** the equipment listed on this form, and I accept full financial responsibility for the care of the equipment while it is in my possession. I agree to be responsible for the replacement at full value of any equipment rented under this form, but not returned to the shop. I agree to return all rental equipment by the agreed date and time.

I understand that the binding system cannot guarantee the user's safety. In downhill skiing, the binding system will not release at all times or under all circumstances where release may prevent injury or death, nor is it possible to predict every situation in which it will release. In snowboarding, the binding system will not ordinarily release during use; these bindings are not designed to release as a result of forces generated during ordinary operation.

I understand that the sport of skiing, snowboarding, and other recreational activities involve inherent and other risks of **INJURY** and **DEATH**. **I voluntarily agree to expressly assume all risks of injury or death** that may result from skiing and snowboarding or which relate in any way to the use of this equipment.

I AGREE TO RELEASE Pats Peak Skiing, LLC, its employees, owners, affiliates, agents, officers, directors, and the manufacturers and distributors of this equipment (collectively "PROVIDERS"), from all liability for injury, death, property loss and damage which results from the equipment user's participation in the sport of skiing/snowboarding, or is in any way related to the use of this equipment, including all liability which results from the NEGLIGENCE OF PROVIDERS, or any other person or cause.

I further agree to defend and indemnify **PROVIDERS** for any loss or damages, including any loss or damages that result from claims or lawsuits for personal injury, death, or property damage related in any way to the use of this equipment.

This agreement is governed by the applicable laws of New Hampshire. If any provision of this agreement is determined to be unenforceable, all other provisions shall be given full force and effect.

I further agree that any claim or suit that I may bring for any reason against the **PROVIDERS** shall be brought only in the state or federal courts of New Hampshire and that I must put the providers on written notice of any claim within sixty (60) days of the event giving rise to the claim.