



ADMISSIONS CONTRACT
PART 1

ADMISSIONS CONTRACT

THIS ADMISSIONS CONTRACT is entered into by and between The Journey: Blazing New Trails, LLC a Utah Corporation hereinafter referred to as "The Facility" and:

(Parent(s)/Legal Guardian(s), etc.) hereinafter referred to as "Sponsor"

IT IS HEREBY AGREED AS FOLLOWS:

1. Student Information: The name, birth date, and social security number of the student are as follows:

Student Name: _____ DOB: _____
Social Security #: _____

2. Sponsor Information: (Note if more than one Sponsor, please provide same information on a separate sheet of paper and attach to this contract)

Name of Sponsor: _____
Street Address: _____
City, State, Zip: _____
Phone Number: _____ Fax: _____ Email: _____

Sponsor Affirms that Sponsor is the legal (Check appropriate Box) of the student:

____ Parent(s) with ____ full ____ joint ____ physical custody of the student
____ Guardian(s) with ____ full ____ joint ____ physical custody of the student

3. Credit Check: Additionally (SPONSORS) agree to a credit check conducted by ("The Facility") for the purpose of qualifying (SPONSOR) for an extended unsecured contractual agreement with ("The Facility")

4. Enrollment of Student in Program: Sponsor hereby enrolls student in ("The Facility") according to the terms of this Admission Contract.

THE JOURNEY PROGRAMS:

IMPACT RANCH

I/we (SPONSOR) agree to pay for a 90 day program to begin _____ 20____.
RECEIVED FROM _____ (SPONSORS), the sum of \$ _____, evidence by _____, as payment for Start Up Cost , including all testing and assessments, Tuition and follow up tracking and therapeutic consultations. Payment in full prior to placement:

- \$15,500
- **The Journey: Blazing New Trails, LLC will only accept cashiers checks, direct deposits and/or credit cards unless student loan arrangements have been made.**

TERM: I/we (SPONSOR) agree to pay \$ 15,500 for this 45 day inpatient / 45 day in home follow-up program prior to placement of my child *unless other arrangements have been made.*

(SPONSOR) agrees not to terminate services prior to the expiration of 90 days. Term shall commence on ___/___/___ and continue until ___/___/___.

Sponsor understands that if the student voluntarily leaves the program or is removed by ("The Facility") pursuant to the terms of this Admissions Contract, Sponsor is still liable to pay ("The Facility") for 1 full month, notwithstanding that the student will no longer be in the ("The Facility") program.

PAYMENT: Payment shall be a one time payment of \$15,500, payable prior to placement of the child.

THE RISING PHOENIX

The monthly tuition is \$4,500 per month with individual/group therapy sessions included. Guardians agree to pay the program upon admission a one time (non-refundable) processing fee of one thousand five hundred dollars (\$1,500.00), and a student Incidental Allowance Account Deposit of one hundred dollars (\$100.00), in addition to the Initial Payment.

- Depending on the Date of Admission, the Initial Payment will be **prorated** as follows:
One hundred and fifty dollars (\$150.00) per day

* **Clarification:** If the Boy is admitted into the Academy on the 19th day of May, the Guardians would pay \$150.00 times 13 (days left in the month of May) which equals to \$1,950. Guardians would then pay the full price of Four Thousand Five Hundred Dollars (\$4,500.00) for the following twelve (12) months, on the first day of each month. Following the Initial Payment, Guardians agree to pay twelve (12) monthly payments of four thousand five hundred dollars (\$4,500.00) each month, and a student Incidental Allowance Account of \$100.00 each month.

The first such payment to be made on or before _____
(Date of Admission) and each monthly payment thereafter shall be due on the 1st (first) day of each month.

*** Guardians can choose to pay twelve (12) months in advance and receive a 5% prepayment discount, which equals one payment of fifty-four thousand dollars (\$54,000), for the twelve (12) months tuition of the program and contract paid in advance, also a student Incidental Allowance Account deposit of one hundred dollars (\$100) for each month, and a one time (non-refundable) processing fee of one thousand five hundred dollars (\$1,500).

The fee schedule remains as stated above (Financial Requirements), unless an (Enrollment Addendum) is authorized by the Program through the Executive Director, even though the Boy may be in the Program less than or longer than twelve (12) months. Monthly payments do not adjust according to the phase of treatment or the services offered, unless an (Enrollment Addendum) is authorized. The monthly payments do not reflect the exact amount of days the Boy will be or is in residence at the Program in any given month. **THERE ARE NO FEE ADJUSTMENTS OR REDUCTIONS FOR PERIODS IN WHICH THE BOY IS NOT PHYSICALLY AT THE FACILITY**, whether or not the Guardian(s) or the program authorizes the boy's absences.

A. INCIDENTAL COSTS AND EXPENSES.

In addition to monthly tuition, the Guardians agree to pay for the following expenses incurred by the Boy; such expenses will be billed to the Guardians monthly as they occur:

1. Medical, dental, orthodontic, optical, urinalysis, lab work, etc.
2. All phone calls from the student or the Academy.
3. Airline or other forms of commercial travel.
4. Transportation and Supervision costs for special needs or activities that are separate from the regular Program of the Academy (doctor, dental appointments, travel to and from airports, Weekly Activities & Super Activities, etc.).
5. Incidental Allowance Expenditures of \$100.00 per month. The incidental allowance expenditures may include, but not be limited such things as personal necessities (deodorant, shampoo, hygiene supplies, school supplies, craft projects, etc.)
6. Cost for additional therapy not covered by the normal Program; Cost of services by the Psychiatrist or Psychologist; Cost for family therapy sessions conducted during family visits, All boys on medication prescribed by a psychiatrist must have a monthly medication review conducted by the Program's psychiatrist at \$80.00 per review. All Boys must have a clinical review of their treatment conducted by the Academy's psychiatrist at \$80.00 per review. A clinical review includes a brief interview with the

Boy, and a consultation and review of treatment progress with the Boy's therapist. Guardians may elect to have their Boy to be seen additionally if they feel the need, by the psychiatrist at \$125.00 per session.

7. The Guardians agree to pay for a comprehensive psychiatric evaluation at \$275.00 if needed or desired by the Guardian or the program.

8. If deemed necessary by the Program or requested by the Guardian, the Program can arrange with a physician for a complete physical, including blood test.

9. Other expenses related to the well-being or needs of the Boy not otherwise provided in accordance with this agreement. Examples of this might be special school activities, vocational training, private tutoring beyond the regular Program, private music lesson, athletics, insurance billings, or other specialized training or activities outside of the regular program.

B. UNUSUAL COSTS

Expenses for the assistance in the return of a runaway boy. In the event that the boy leaves the Program without authorization, the Program will use reasonable efforts to assist the Guardian(s) in finding the boy and in obtaining his safe return. An accounting of the expenses incurred by the Program while assisting the Guardian(s) in finding and returning the Boy will be made to the Guardian(s). Responsibility for damage to or loss of property caused by the Boy. Guardian(s) agree to be financially responsible for the costs of repairing or replacing any property lost, stolen, damaged, defaced, or destroyed by their son that are not covered by insurance. Such costs will be billed to the Guardian(s) at the time such damage or loss occurs and shall be paid by the Guardians within ten (10) days of receipt of bill.

Cost of Collections, Attorney Fees, and Interest. Guardians agree to pay the costs of the collection of any amounts due under this agreement, including reasonable attorney's fees, whether or not legal action is commenced and in addition to pay interest (2%) on all sums unpaid within 10 days after the due date.

DEFAULT: Any failure by (SPONSOR) to pay weekly installment when due, or perform any term hereof, shall, at the option of ("The Facility") be subject to a lien on all unpaid monthly installments in favor of ("The Facility"), for payment of all sums due hereunder, to the maximum extent allowed by law. In the event of a default by (SPONSOR), ("The Facility") may elect to (a) continue the contract in effect and enforce all his rights and remedies hereunder, including the right to recover weekly installments as they become due, or (b) at any time, terminate (SPONSORS) contract hereunder and recover from (SPONSOR) all damages, he/she may incur by reason of breach of the contract, including the cost of recovering the weekly installments plus interest, and include the worth at the time of such termination, or at the time of an award if suit be instituted to enforce this provision.

COLLECTIONS: Under this contract it is understood and agreed that when (SPONSORS) is/are in default of past due charges and monthly installments, (SPONSORS) agree to pay all attorney's fees, all court costs, filing fees and charges or commissions of fifty percent that may be assessed by any collection agency retained to pursue this matter.

ATTORNEY'S FEES: In the event that ("The Facility") shall prevail in any legal action brought about by either party to enforce the terms hereof or relating to this contract or services, ("The Facility") shall be entitled to all costs incurred in connection with such action, including reasonable attorney's fee.

5. Student Representation and Responsibilities: Both the student and the Sponsor understand that the student is to follow the program rules and expectations listed below:

a. Participation: Student and Sponsor understand that the program is a therapeutic

program including: education, experiential education, individual and group counseling, service projects, and therapeutic/recreational activities that are rigorous and demanding. Sponsor and student accept stressful physical and mental challenges for being a part of the treatment program. The student agrees to participate in all activities.

b. Drug Free Program: One of the purposes of the program is to encourage the students to become drug free. The student agrees to abstain from all forms of nicotine, alcohol, marijuana, hallucinogens, stimulants, depressants, opiates, inhalants and prescription drugs that are not prescribed to the student. Furthermore student may be personally searched and may have his belongings searched at any time and any place for the purpose of discovering any of the above named substances and or weapons.

c. Drug Testing: Sponsor and Student agree to a full drug screen, urine/blood test and a routine medical physical will be given by medical personnel selected by Turning Point in the event that Turning Point and/or staff deem it necessary. All costs of such tests, physicals/medical appointments and dental appointments shall be the sole cost and expense of the Sponsor.

d. Restraint: The Sponsor and the student authorize ("The Facility") personnel to physically restrain and control the student with whatever force is required to prevent the student from hurting or jeopardizing the safety of the student and/or others, in the sole discretion of ("The Facility") /personnel if the need arises.

e. Mail: The Sponsor and the student understand that the student may only receive mail from the people that are on the approved mailing list. All other mail will be redirected to the sponsor.

f. Phone Calls: The Sponsor and the student understand that the student will have no phone calls home during the program, with the exception conference calls with the therapist student and parents.

g. Completion of the Program: The Sponsor and the student understand that the student must successfully complete each phase of the education curriculum, program criteria and personal growth curriculum before the student will graduate from the program. Therefore, although a specific minimum time has been scheduled, the student will be expected to continue the program past the scheduled program date, if the student has not satisfactorily completed the requirements for graduation as outlined in a manner acceptable to the ("The Facility") staff. Provided however, at the Sponsor's discretion, after discussion with the ("The Facility") staff, Sponsor may opt to remove the student from the program before graduation, and be legally responsible for the costs outlined under the Term and Payment section of this Admissions Contract.

h. Sponsor Participation in the Program: Sponsor(s) understand that participation by the Sponsor(s) and/or other family members is extremely important to the success of the student once they graduate from the program. Therefore, Sponsor(s) agree that they will participate in family counseling and training material suggested by the ("The Facility") staff at or before graduation and release of the student.

6. Medical Treatment: Sponsor and the student understand that it is critical that a complete medical history be provided with respect to the student prior to entry in the program, and that medical form provided by ("The Facility") is accurately and completely filled out. Sponsor agrees to be responsible to costs incurred by ("The Facility") during the program as a result of inaccurate or incomplete medical information on the student. In the sole discretion of ("The Facility") and/or staff, in the event medical treatment is needed for the student during the program, the Sponsor and the student authorize qualified ("The Facility") staff to provide or obtain medical treatment (emergency or otherwise) for student and authorize such medical doctors or other personnel, hospital or other appropriate medical facility to administer medical or surgical treatment according to their professional discretion, at the sole cost and expense of the Sponsor. In the discretion of ("The Facility") Staff, should the student require medical evacuation, the Sponsor must pay the cost of the evacuation, transportation and out-processing. There will be no refund of tuition as per this contract and the total evacuation cost will be due and payable upon demand by ("The Facility") . The Sponsor and the student understand that major medical treatment beyond immediate First Aid and CPR may be more than an hour away when on adventure outings.

7. Authorization for Release of Information: The Sponsor and the student authorize any and all psychologist, medical doctors, hospitals, treatment centers, counselor, therapist and /or others that have counseled or treated the student and whose names have been provided to ("The Facility") , to release all information regarding medical or psychological, history, diagnosis, treatment or disability to ("The Facility") personnel. Sponsor and the student agree to execute any additional forms necessary for ("The Facility") to obtain such information.

8. Informed Consent Release, Confidentiality: With a few legal exceptions, the information shared with ("The Facility") instructors, therapist, counselors and agents has the status of privileged communication and cannot be revealed to anyone else, unless a Consent to Release Form has been signed by the Sponsor (a Consent to Release Form has been provided in the Enrollment Packet).

9. Removal of the Student from the Program by "The Facility": Is the sole discretion of ("The Facility") , the student agrees that the Sponsor may be notified by ("The Facility") to make arrangements for immediate removal of the student from the program. ("The Facility") is hereby authorized to contact the following person(s):

Person to Contact: _____ Phone: _____
Fax: _____ Email: _____

Alternate Contact: _____ Phone: _____
Fax: _____ Email: _____

In the event ("The Facility") is unable to reach the person designated by Sponsor for removal of the Student (the "Contact") ASAP, or in the event ("The Facility") reaches the contact and request removal, but the contact refuses or fails to remove the student within (24) twenty-four hours of notification, then Sponsor and the student authorize ("The Facility") /staff to make such arrangements as ("The Facility") deems appropriate to have the student removed, at the sole cost and expense of the Sponsor. Sponsor and student understand that ("The Facility") will take appropriate measures.

10. Leaving Program Area without Permission: ("The Facility") will use reasonable efforts and procedures to prevent students from leaving the ("The Facility") Facilities or Program Area without permission and to locate and return any runaway students. However, once ("The Facility") determines that the student is AWOL (Absent Without Official Leave), Sponsor shall assume the responsibility to return the student to ("The Facility") Facility at Sponsor's own cost and expense. In the event that the student becomes (AWOL). Sponsor will pay for all costs incurred by local officials associated with locating the student and returning them to the program and or home. ("The Facility") will make a reasonable effort to locate your student prior to contacting local and state officials

11. Acknowledgment of Risks: Sponsor and Student understand and acknowledge that some of the activities that the student is about to engage in bear certain known risks and unanticipated risks which could result in injury, death, illness, disease or damage to the student or the students property. Such risks include but are not limited to the following:

- a. The nature of wilderness day excursions and the particular risks of the activities themselves, which include hiking and camping in the outdoors. Those activities include risks normally encountered in a desert/mountain/river environment and include but are not limited to risks such as heat/cold, slick rocks, flash floods, lightning, falling trees/rocks and other adverse weather conditions.
- b. Acts of other students, employees and agents of ("The Facility").
- c. Conditions of roads, trails or terrain and accidents connected with their use.
- d. Unavailability of immediate medical treatment beyond first aid emergency treatment in case of injury.

12. Acceptance of Risks and Responsibilities: Being aware that the program entails risks, both known and unknown, of injury to the student and the student's property, as a result of the student's actions and/or the actions of others. Sponsor and the student agree, covenant and promise that the student shall accept and assume all responsibility and risk of injury, death, illness, disease, or damage to the student or the student's property arising from the student's participation in this program. Sponsor and the student elect to have the student participate in the program in spite of the risks.

13. Waiver and Indemnification: Sponsor and the student, on behalf of themselves, their agents, successors and assigns, hereby waive any and all claims which may arise as a result of the student's participation in the program, including claims that ("The Facility") or its personnel have been negligent, against ("The Facility") , ("The Facility") Officers, directors, personnel and agents, including but not limited to, all liability for personal injury and/or property damage. It is understood and agreed by Sponsor and the student that enrollment of the student in the program is expressly contingent upon this waiver and that ("The Facility") agreeing to provide services hereunder and enroll the student in the program are considerations for such waiver and that ("The Facility") is relying upon said waiver as a material term and condition of this Admission Contract and providing services hereunder.

Sponsor further more agrees that Sponsor will indemnify and hold harmless ("The Facility") from any and all claims, causes of action, or suits filed or asserted by third parties on behalf of themselves and/or on behalf of the student in connection with the services of ("The Facility") provided to the student under the Admissions Contract and/or by reason of the acts or omissions of the student including, but not limited to, claims asserting that ("The Facility") was negligent in its care, management, or control of the student. Sponsor understands that ("The Facility") is entering into this Admissions Contract with the express representation and understanding that if the student and/or any third party files suit against ("The Facility") connection with any services provided by ("The Facility") , it is the intent and understanding of the parties that ("The Facility") will be indemnified and held harmless by Sponsor in connection with any such claims, including legal fees incurred on appeal, and whether or not suit is filed. It is the intent of this clause and the parties hereto to eliminate any such claims by the student and/or third parties, but in the event such claims are made, the responsibility to indemnify, hold harmless and defend ("The Facility") shall be the sole responsibility of the Sponsor.

14. Fees & Costs: In addition to the other responsibilities for costs set forth herein, Sponsor shall be responsible for the following fees and costs hereunder.

- a. Additional Days:** (IMPACT RANCH) Additional days that the student stays in the program shall be charged at \$300 per day. (RISING PHOENIX) Additional days that the student stays in this program shall be charged at \$150.00 per day. If your student exceeds the outlined program you will be expected to pay the pro-rated days at the beginning of each additional week
- b. Processing Fee:** (IMPACT RANCH) There is a one time \$500.00 non-refundable processing fee for each resident entering the program. (RISING PHOENIX) There is a one time \$1500.00 processing fee for each resident entering the program. If a credit card is to be used to pay the program start up cost, tuition or other related costs, ("The Facility") will charge an additional 2.7% processing fee.
- c. Medical/Dental and Hospital Expenses:** Sponsor agrees to pay or arrange for his/her insurance to pay for all medical, dental and hospital expenses for and on behalf of the student.
- d. Damages committed by the student;** Sponsor shall be responsible for all damages and costs incurred by the acts or omissions of the student including property damage, personal injury to self or others, or damages resulting from criminal activity by the student.
- e. Personal Items:** Sponsor is required to purchase and/or pay for all personal items required on the equipment list for the student.
- f. Advanced Cost, Interest:** ("The Facility") shall not be responsible to advance costs that are the responsibility of the Sponsor. However, if ("The Facility") does advance costs that are the responsibility of the Sponsor, Sponsor agrees to reimburse ("The

Facility”) for such costs plus interest at the rate of (14%) per annum from the date such costs were advanced.

g. Medical exam (PHYSICAL): For the safety of all the participants in our program, it is required to provide a current physical examination upon admission to the facility (within 6 months before placement). The attached form must be filled out by the health care provider conducting the exam. The facility can provide a physical exam at \$200.00 which needs to be paid upon admission and can later be billed to your insurance for reimbursement.

15. Legal Fees: The parties hereto agree that (“The Facility”) shall be entitled to legal fees for the enforcement of this Admission Contract, or any of it’s provisions, including such fees as are incurred upon appeal and whether or not suit is filed, including, but not limited to, attorney’s fees for enforcing any waivers and indemnifications, and attorney’s fees for collections of amounts due hereunder.

16. Law: This Admission Contract shall be governed by the laws of the State of Utah.

_____	_____
“The Facility”	Date
_____	_____
SPONSOR	Date

Student understands that student is agreeing to be bound by the terms and conditions of the Admission Contract as entered into between (“The Facility”) and the Sponsor. Student further understands that if student is a minor, the student’s Sponsor can read each provision to the student and sign this contract on the student’s behalf.

_____	_____
STUDENT	Date

If there is more than one Sponsor, Sponsor agrees that each Sponsor shall be both jointly and severally liable hereunder.

_____	_____
SPONSOR	Date
_____	_____
SPONSOR	Date

(SPONSOR) and (“The Facility”) enter this agreement on this ____ day of _____, 20__

Signature of Sponsor
(Father /Guardian)

Signature of Sponsor
(Mother /Guardian)

CREDIT CARD POLICY

For your convenience ("The Facility") has become a merchant for Visa, Master Card, Discover (2.5% finance charge will be added), and American Express. (3.1% finance charge will be added) credit cards. Credit cards can be used for the following:

1. Start Up Cost.
2. Tuition upon enrollment.
3. Clothing Items etc. you were unable to purchase prior to your child entering the program.
4. Medical Bills, (where insurance is not available)

POLICY FOR CREDIT CARD USE: In the event that your child is in need of one of the items mentioned above, a call will be made to you to authorize the purchase. ("The Facility") will then purchase the item with your authorization, we will bill your credit card. In the event that a credit card is not available for purchasing the items mentioned above, upon authorization from you, those purchases will be made by ("The Facility") and you will be billed for the items that your child needed.

Credit Card #: _____ **Expiration Date:** _____

Credit Card Type: _____

Signature of Cardholder: _____

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that we _____ (hereinafter the "sponsor"), residing at _____, do hereby make, constitute, and appoint **The Journey: Blazing New Trails, LLC**, a Utah Corporation hereinafter referred to as "The Facility", to be the true and lawful attorney, in fact for _____ (hereinafter the "Student"), who is my/our _____ for the purpose of providing custodial care, education, therapeutic and clinical services in connection with ("The Facility").

Without limiting or qualifying the general Power of Attorney and delegated by the Sponsor to ("The Facility") in the paragraph above, Sponsor specifically grants to ("The Facility") the following powers.

1. To provide or obtain all medical, dental and psychiatric treatment and hospital care, and to authorize a physician to perform all procedures, that may appear to be medically necessary for the well being of the student.
2. To guide and discipline the Student as deemed necessary and reasonable by ("The Facility") in accordance with the State of Utah, Office of Licensing Code of Conduct. (not to include physical punishment.)
3. To physically restrain the student should he/she become a danger to him/herself or to anyone others or property according to the State of Utah, Office of Licensing Code of Conduct.
4. To allow the Student to participate in all activities that may risk physical injury or illness, as outlined in the ("The Facility") Enrollment Contract and Program Overview/Description.
5. To search the student and his/her personal property at any time and confiscate any items deemed by ("The Facility") to be illegal or dangerous contraband or items which are counterproductive to the Student's successful completion of the program.

This Power of Attorney shall be effective for a period of approximately _____/or for the duration of the contracted care upon termination of the student.

IN WITNESS WHERE OF, I/we have executed this Power of Attorney this ____ day of _____, 20__

Signature of Sponsor
(Father / Guardian)

Signature of Sponsor
(Mother / Guardian)

State of County of _____
On this ____ day of _____, 20____, personally appeared before me foregoing Power of Attorney, who duly acknowledged to me that they execute the same.

NOTARY PUBLIC Residing At:

Acceptance
("The Facility")

By: _____ Date: _____

MUST BE NOTARIZED

THE JOURNEY: BLAZING NEW TRAILS, LLC.
PHYSICAL EXAM
MEDICAL HISTORY QUESTIONNAIRE
(To be completed by the client)

Date: _____ Social Security Number: _____
Name: _____
Address: 1933 North 1120 West _____ Telephone: 801-375-4240
Age: _____ Date of Birth: _____ Gender: Male: ___ Female: ___
Allergies: _____ Have you had a DT shot in the last 5 years: _____
Current Medications: _____
Have you had medication for a psychological reason in the past? _____
If yes, what medication? _____
Did you also receive counseling? _____ If yes what for? _____
Have you ever thought about or attempted suicide? ___ If Yes, when? _____
Current or Recent Medical Problems (injury, surgery, illness): _____
Long Term Medical Problems: _____
Are you experiencing any pain? No ___ Yes ___ DETAILS: _____
Have you had any history of accidents, broken bones, surgeries, transfusions or hospitalizations? No ___ Yes ___ If Yes, please explain: _____

Do you currently have any of the following:

Asthma ___ Seizures ___ Heart Problems ___ Stomach Problems ___
Diarrhea ___ Kidney Problems ___ Hay Fever ___ Teeth Problems ___
Tuberculosis ___ Eye Problems ___ Ear Problems ___ Frequent Headaches ___
Problems Sleeping ___ Depression ___ Anger Problems ___ Mood Changes ___
Nervousness ___ STD ___ Suicidal Thoughts ___

Have you ever passed out during exercise? No ___ Yes ___
Have you ever had chest pain during or after exercise? No ___ Yes ___
Has any family member or relative died of heart problems or a sudden death before age 50? ___ If Yes, please explain: _____

Self Report of Drug Use:

Have you used drugs in the last 48 hours? ___ If yes, what drug? _____
Have you used any of the following in the past: Tobacco ___ Alcohol ___
Marijuana ___ Cocaine ___ Crystal Meth ___ Opium ___ Heroin ___
Mushrooms ___ Acid ___ Abused prescription drugs ___

THE JOURNEY: BLAZING NEW TRAILS

THE JOURNEY: BLAZING NEW TRAILS, LLC. PHYSICAL EXAM

Name: _____ Height: _____ Weight: _____

Pulse: _____ Blood Pressure: _____ UA: _____

V20.2 Routine physical/ Child Health Exam

		NORMAL	ABNORMAL FINDINGS
1	Eyes: L /20 R /20		
2	Ears, Nose, Throat		
3	Mouth and Teeth		
4	Neck		
5	Cardiovascular		
6	Chest and Lungs		
7	Abdomen		
8	Skin		
9	Genitals-Hernia		
10	Muskoskeletal: ROM Strength, etc.		
11	Knee and ankle stability		
12	Neurological		

Comments RE: Abnormal findings or concerns about program participation:

The program will include hiking in sometimes severe weather conditions carrying a backpack weighing up to 30% of the client's body weight and elevations up to 11,000 feet. Also included in the program will be physical exertion for work and may include contact with animals, dust, pollen and insects including bees and wasps.

PARTICIPATION RECOMMENDATIONS:

____ Full Unlimited Participation ____ No Participation

____ Clearance pending documented follow-up of: _____

Licensed Professional's Name (PRINT) Date

Licensed Professional's Signature Telephone

THE JOURNEY: BLAZING NEW TRAILS



CHECK LIST FOR ADMISSIONS

The Journey: Blazing New Trails enrolls students on a year round basis. Please use the check list below to ensure you have completed and supplied all the necessary information. Please call us if you have any questions.

ENROLLMENT APPLICATION: Complete the application form, sign and date all places where signatures are required. Please return completed form to our admissions office as soon as possible.

TESTING AND PSYCHOLOGICAL EVALUATIONS: Please include copies of all testing that has been done on your son. This enables us to determine the appropriateness and fit of the Academy and your son.

SCHOOL TRANSCRIPTS: An official copy of the student's transcripts should be sent our admissions office. One must also be sent to the academic institution we will use for student classes.

COURT DOCUMENTS REGARDING CUSTODY AGREEMENTS: These are required in the case of divorce or guardianship. We must know who has custody, and authority to permit travel out of the USA.

SIGNED ENROLLMENT AGREEMENT

COMPLETED INSURANCE INFORMATION

ADMISSIONS CORRESPONDENCE

The Journey: Blazing New Trails
1933 North 1120 West.
Provo, UT. 84604

THE JOURNEY: BLAZING NEW TRAILS

Email: tyler.thejourney@gmail.com
Phone: 801-615-0213
Fax: 801-375-4241

STUDENT INFORMATION

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____ Social Security No. _____ Date of Birth: _____

Birth Place: _____ Current Grade Level: _____ Religious Preference: _____

Eye Color _____ Hair Color _____ Height: _____ Weight: _____ Race/Ethnicity: _____

Identifying Marks _____

Was Student Adopted? Yes No Age Adopted _____ Citizenship _____

Is your child presently living at home? Yes No

If NO, please explain

REFERRAL INFORMATION

How did you first hear about The Journey?

Educational consultant Psychiatrist Internet Web Site Journey parent, friend or family

Other _____.

If a specific person referred you please provide the information asked for below:

Name of Referral Source _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Telephone _____

CUSTODY INFORMATION

A copy of all court orders and agreements relating to custody of the student MUST be submitted with this application.

Are parents divorced? Yes No If yes, who has legal custody? _____

Date Divorce Final _____ Where? _____

EMERGENCY CONTACT INFO

In case of an emergency and parents cannot be reached.

Name _____ Relationship _____

Telephone/Home _____ Work _____ Fax _____

PARENT/LEGAL GUARDIAN INFORMATION

Please provide all requested information on family members

FATHER'S LEGAL NAME:

Social Security No. (last 4 digits) _____ Legal Custody? Yes No

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone/Home _____ Work _____ Fax _____

Cellular _____ E-mail _____

Business Address _____ City _____ State _____ Zip _____

Occupation _____ Title _____

Father Deceased? Yes No Date of Death _____

MOTHER'S LEGAL NAME:

Social Security No. _____ Legal Custody? Yes No

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone/Home _____ Work _____ Fax _____

Cellular _____ E-mail _____

Business Address _____ City _____ State _____ Zip _____

Occupation _____ Title _____

Mother Deceased? Yes No Date of Death _____

Is there a financial sponsor other than parents? Yes No

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone/Home _____ Work _____ Fax _____

Cellular _____ E-mail _____

Business Address _____ City _____ State _____ Zip _____

Occupation _____ Title _____

STEP-FATHER'S LEGAL NAME:

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone/Home _____ Work _____ Fax _____

Cellular _____ E-mail _____

Business Address _____ City _____ State _____ Zip _____

Occupation _____ Title _____

STEP-MOTHER'S LEGAL NAME:

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone/Home _____ Work _____ Fax _____

Cellular _____ E-mail _____

Business Address _____ City _____ State _____ Zip _____

Occupation _____ Title _____

GUARDIAN/CUSTODIAN'S LEGAL NAME (If Other than Biological Parent):

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone/Home _____ Work _____ Fax _____

Cellular _____ E-mail _____

Business Address _____ City _____ State _____ Zip _____

Occupation _____ Title _____

Please list all educational consultants, psychiatrists, psychologists, and/or counselors/therapists who have worked with the student. Indicate those professionals who will continue to be involved with the student and should receive Progress Updates from The Journey: Blazing New Trails, LLC.

Name _____ Progress Updates Yes No

Dates of Service: From _____ To _____

Address _____ City _____ State _____ Zip _____

Telephone/Work _____ Fax _____ E-mail _____

Name _____ Progress Updates Yes No

Dates of Service: From _____ To _____

Address _____ City _____ State _____ Zip _____

Telephone/Work _____ Fax _____ E-mail _____

Name _____ Progress Updates Yes No

Dates of Service: From _____ To _____

Address _____ City _____ State _____ Zip _____

Telephone/Work _____ Fax _____ E-mail _____

Is Student Currently on Probation? Yes No Date Probation Ends _____

Please attach a copy of probation order.

Probation Officer's Name _____ Progress Updates Yes No

Address _____ City _____ State _____ Zip _____

Telephone/Work _____ Fax _____ E-mail _____

Reason for Probation/Dates _____

I/We hereby authorize the above professional(s) to release information regarding the above named student to The Journey: Blazing New Trails, LLC and authorize the The Journey: Blazing New Trails, LLC to release information regarding the student to the professional(s) above.

Parent/Guardian _____ Signature _____ Date _____

Parent/Guardian _____ Signature _____ Date _____

PREVIOUS PLACEMENTS

Please list placements outside of the home: boarding schools, foster homes, psychiatric, hospitalizations, etc.

Name and Location _____

Dates of Placement: From _____ To _____

Reason for Placement and Subsequent Departure

Name and Location _____

Dates of Placement: From _____ To _____

Reason for Placement and Subsequent Departure

Name and Location _____

Dates of Placement: From _____ To _____

Reason for Placement and Subsequent Departure

MEDICAL/BEHAVIORAL HISTORY

Please indicate if the student has experienced any of the following:

YN	YN	YN
ADD/ADHD	Serious medical problems	Suicidal gestures or threats
Counseling	Behavior Problems	Fire setting
Promiscuity	Drug and alcohol abuse	Self harm, self mutilation
Learning Difficulties	Special placements,	Arrests
Emotional Problems	Depression	Juvenile probation
Runaway	Violent behavior	Significant events (deaths, Illnesses, moves, divorce)

Please indicate by checking the box if the student has had any of the following diseases or illnesses, and indicate the age at which it occurred.

YN	
Asthma or shortness of breath-	Coughing-
Frequent or Migraine headaches-	Seizures, convulsions-
Birthmarks, tattoos, body piercing-	Diabetes/Hypoglycemia-
High/Low blood pressure-	Skin sores or rashes-
Bloody Noses-	Diarrhea/Constipation-
Orthodontics, Braces or Retainer-	Special Diet-
Chest Pain/heart problems-	Dizziness or fainting Spells-
Pain in back, knees, joints, neck-	Stomach aches, indigestion-

Ear Pain or hearing problems-
Surgeries, illnesses or broken bones-
Unexplained weight gain/loss-

Scoliosis-
German Measles
AIDS/HIV+

Eczema -

Bone Condition-

Arthritis-
Mononucleosis-
Ulcers -
Epilepsy-
Anemia-

STUDENT NAME:

If yes to any of the above, list date, doctor name, address, hospital or explanation:

I represent that the above information is correct to the best of my knowledge and belief. In consideration of professional services rendered to the above student, I agree to pay the customary medical services. I hereby authorize the Doctor to receive assignment of insurance benefits, and agree to pay any unpaid benefits under my insurance plan. I also understand & agree to pay additional finance, collection or legal fees should my account be placed with a collection agency for non-payment. I authorize the release of medical information that may be necessary for medical care or to my insurance company for processing of insurance benefits.

Parent Signature _____ **Date** _____

List any current or previous health problems or concerns affecting the student

Is the student currently on any medications? Yes No (If yes, please list medications and dosage)

Please List Medication History

Does the student have any allergies? Yes No

Food or other allergies (Describe)

Other reactions (Hives, Hayfever, Eczema, Asthma, Etc.)

Has the student had any serious injuries? Yes No

Has the student ever been hospitalized for medical reasons? Yes No

STUDENT NAME:

HISTORY OF SUBSTANCE USAGE/ABUSE

	Age of first Involvement	Amount used per week	Date of last Use
TOBACCO			
ALCOHOL (wine,beer)			
HARD LIQUOR			
MARIJUANA			
HASHISH			
LSD			
PCP			
CRACK			
COCAINE			
CRANK			
HEROIN			
METHADONE			
METH			
GLUE			
PAINT THINNER			
AEROSOL			
OTHER:			

Is there anything else regarding your child's substance usage/abuse we should know:

Has your child ever been accused of sexual or physical abuse? Please describe your impressions of what happened and the date of occurrence.

STUDENT NAME:

Has your child ever witnessed or been traumatized by physical abuse, sexual abuse, a death, violence? If yes, please explain.

Is your child sexually active? Please describe history.

Has your child ever demonstrated violent behavior? If yes, please explain

Has your child ever attempted suicide? If yes, please explain

STUDENT NAME:

Has your child had any involvement with the legal system? If yes, please explain.

Please describe your child's strengths

Please describe your child's weaknesses:

Please rate and describe your child's behavior in the following areas of major concern:

(1) FAMILY (2) SCHOOL (3) COMMUNITY (4) PERSONAL/SOCIAL

The rating scale is a simple way to quantify your judgements regarding your child. Please note: the number you circle should reflect your general evaluation of how your child was adjusting in the area suggested (i.e. "Family"). For example, a "2" would mean your child was generally doing very poorly, while a "6" would indicate a little better than average and a "10" he/she could hardly be doing better.

1. FAMILY: (discipline, getting along with siblings and parents, use of or abstinence from alcohol drugs, sharing, communication, thoughtfulness and consideration of others, etc.)

Very negative- negative -positive -very positive
1 2 3 4 5 6 7 8 9 10

Please explain:

STUDENT NAME:

2. SCHOOL: (discipline, attendance, academic failure/success, athletics, peer group getting along with teachers, etc.)

Very negative- negative -positive -very positive
1 2 3 4 5 6 7 8 9 10

Please explain:

3. COMMUNITY: (involvement or non-involvement in illegal activities or use of drugs or alcohol, was he/she working, respectful of others rights and property, etc.)

Very negative- negative -positive -very positive
1 2 3 4 5 6 7 8 9 10

Please explain:

4. PERSONAL / SOCIAL (communication abilities, moods, attitudes, interests, character traits, personal goals, self-image, friends, etc.)

Very negative- negative -positive -very positive
1 2 3 4 5 6 7 8 9 10

Please explain:

Thank you for the time and effort you took to answer all the questions.

STUDENT NAME: _____

PARENTS/GUARDIAN affirm that they are the legal _____ with _____
Custody of: _____
Parents/Guardian Full Legal/Joint/physical
Name of Child

RELEASE OF MEDICAL INFORMATION

I/We hereby authorize the release of any medical information regarding the above named student to The Journey: Blazing New Trails, LLC and authorize The Journey: Blazing New Trails, LLC to release information regarding his prior medical history to medical providers as deemed necessary to facilitate student’s medical care.

DISCLOSURE OF RECORDS TO/FROM TREATMENT PROVIDERS

Disclosure may be made to or received from treating or evaluating medical doctors, nurses, dentists, counselors, social workers, psychologists, psychiatrists and any other person or entity which The Journey: Blazing New Trails, LLC believes to be in the interests of the youth. Disclosure may include disclosure of conditions, observations, records and any other information that The Journey: Blazing New Trails, LLC believes is relevant to student’s physical or mental condition. Counseling, treatment and medical information and records may be provided to said treatment or evaluation providers or any other person or entity that The Journey: Blazing New Trails, LLC determines would benefit from the provision and said information for the treatment and/or counseling of student.

CONSENT TO MEDICAL AND DENTAL EXAMINATION AND TREATMENT

I/We hereby authorize and consent to any physical examination, X-ray, anesthetic, inoculation, vaccination, medical or surgical or surgical diagnosis or treatment and hospital care for the above named student under general or special supervision and upon the advice of a physician licensed to practice medicine in such country where services are rendered. I/We hereby consent to X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said student by a dentist licensed to practice dentistry in such country where the services are rendered. Students requiring medications must be pre-approved by The Journey: Blazing New Trails, LLC. All students on medications must bring a 45-day supply of prescriptions.

RELEASE OF MEDICAL INSURANCE INFORMATION

I/We hereby authorize the release of any medical insurance information necessary to process any insurance claims regarding the above named student, to The Journey: Blazing New Trails, LLC and medical providers.

PARENT CONSENT TO PSYCHOLOGICAL/PSYCHIATRIC SERVICES

I/We hereby authorize The Journey: Blazing New Trails, LLC to refer above named student to approved clinical services staff in the event he is in need of psychological/psychiatric services. Payment for services rendered will be made by the undersigned to The Journey: Blazing New Trails, LLC.

PARENT CONSENT TO TEST

I/We hereby give consent to The Journey: Blazing New Trails, LLC to administer tests to the above named student that are pertinent and appropriate. The tests may include psychological and/or academic tests.

I/WE HAVE READ AND UNDERSTAND ALL CONSENTS, RELEASES AND AGREEMENTS SET FORTH ON THIS PAGE, AND I/WE EXECUTE THEM VOLUNTARILY.

Parent/Guardian Signature _____ Date _____
Parent/Guardian Signature _____ Date _____

PARENT’S/GUARDIAN’S CONSENT FOR STUDENT TO TAKE PART IN THE PROGRAM

a. I/We consent for the student to take part in all activities of the program, and hereby acknowledge that he/she/they is/are fully aware that parts of the program are demanding and rigorous, and do hereby consent to permit and give legal authority to the representatives of the THE JOURNEY to have my son/daughter participate in program activities as may be deemed appropriate by the THE JOURNEY administration.

I realize that in so consenting, I hereby release and indemnify the said organization and its agents and employees, from all loss, damages, injury, liability suits and proceedings, claims or demands, in law or in equity, that I might have against any of them by reason of such program participation

b. I/We give express authority to THE JOURNEY personnel to utilize reasonable physical force upon student in order to protect the student, THE JOURNEY personnel or others from physical injury or threat of injury from student while providing said escort services. I/We hereby give express authority and consent to THE JOURNEY personnel to utilize reasonable physical force to restrain, control and detain the student for and including, but not limited to , the following purposes: transport to or from THE JOURNEY; to prevent the student from running away from THE JOURNEY; to protect property, protect THE JOURNEY personnel or others from physical injury or threat of injury from the student.

RESPONSIBILITIES FOR ILLNESSES INJURIES OR ACCIDENTS. I/We shall indemnify and hold harmless THE JOURNEY for any injuries, illnesses or other damages occurring to the student during the term of enrollment. Including any resulting from the student taking part in the programs and activities of THE JOURNEY.

AUTHORIZATION FOR SEARCH. I/We hereby give consent and authorize THE JOURNEY to search the personal effects and person of the student. THE JOURNEY is hereby authorized to confiscate any and all items deemed by THE JOURNEY as contraband.

TRANSPORTATION CONSENT AND RELEASE. I/We hereby authorizes THE JOURNEY, at its sole discretion, to place the above named student on a public carrier (i.e. airplane, train, bus, etc.) for the purpose of transporting him to such location as communicated by the undersigned to THE JOURNEY, or THE JOURNEY to the undersigned.. I/We hereby release and discharge THE JOURNEY, its agents, employees, officers, directors, and affiliated entities from all claims demands, actions, judgments, and executions the undersigned may have against THE JOURNEY for all personal injuries, known or unknown, and injuries to property, personal or real, caused by or arising out of the removal and transportation of the student from THE JOURNEY.

I/WE HAVE READ AND UNDERSTAND ALL CONSENTS, RELEASES AND AGREEMENTS SET FORTH ON THIS PAGE, AND I/WE EXECUTIVE THEM VOLUNTARILY.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

STUDENT NAME: _____

BENEFITS TO PHYSICIAN AND/OR ALTERNATIVE TREATMENT FACILITY

.. I hereby authorize payments directly for surgical and/or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company.

Signature of Sponsor _____ (Father/Guardian) Date _____
Signature of Sponsor _____ (Mother/Guardian) Date _____

APPENDIX A: INSURANCE INFORMATION

Please provide a photocopy of the front and back of your medical and dental insurance coverage

Insurance Company _____
Address _____ City _____ State _____ Zip _____
Telephone/Work _____ Fax _____
Policy Holder _____
Policy No. _____ Group No. (If applicable) _____
Employer (IF group policy) _____
Coverage (Emergency, mental health, etc.) _____
Pharmacy Card No. _____ Pharmacy Deductible _____

SIGNATURE OF POLICYHOLDER _____ Date _____

Please provide a photocopy of the front and back of your medical and dental insurance coverage

Insurance Company _____
Address _____ City _____ State _____ Zip _____
Telephone/Work _____ Fax _____
Policy Holder _____
Policy No. _____ Group No. (If applicable) _____
Employer (IF group policy) _____
Coverage (Emergency, mental health, etc.) _____
Pharmacy Card No. _____ Pharmacy Deductible _____

SIGNATURE OF POLICYHOLDER _____ Date _____

APPROVED MAIL LIST

I hereby give consent for my child: to only receive mail from those specific persons named below.

Student Name: _____

NAME	
ADDRESS	
NAME	
ADDRESS	
NAME	

STUDENT NAME:

ADDRESS	
NAME	
ADDRESS	

Signature of Parent or Guardian _____ Date _____