



APPLICATION: PARENT STATEMENT

To be completed by the parent or guardian:

1. I understand that Colorado Timberline Academy requires all students to carry standard student accident insurance. My child is covered by policy number _____ with (Company) _____
Phone # _____
(address) _____
2. I agree to meet the financial obligations outlined on the Fee Agreement enclosed in the catalog.
3. Having read the rules, I am in accord with the philosophy and ideals of the Colorado Timberline Academy and pledge my support to the faculty in implementing the program.
4. I will provide full disclosure of any and all pertinent physical, academic or emotional needs or special problems which may have prompted my child's application or may impact on their behavior at Colorado Timberline Academy.
5. If my child is put on any prescription medication during the academic year, I will immediately notify the school.
6. I understand that Colorado Timberline Academy will try to contact me by telephone in case of medical emergency for my child. However, in case I cannot be reached by telephone, I hereby delegate to the director, or his designated representative, the authority to authorize and consent to any and all medical, surgical, dental or hospital care or treatment for my child while a student at Colorado Timberline Academy. Such treatment is to be rendered only by a duly licensed physician or dentist. The faculty is fully authorized to act in accordance with their own judgment in any such emergency and are absolved from any liability or financial responsibility in connection therewith.

Parent or Guardian Signature

Date

PERMISSION FOR MEDICATION

AND ALLERGY INFORMATION

NAME OF STUDENT

ALLERGIES TO MEDICATION?

ALLERGIES TO FOOD?

MEDICATION(s).....

DOSAGE

PURPOSE OF MEDICATION

POSSIBLE SIDE EFFECTS

.....
.....

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

.....

DATE.....

signature of physician

I HEREBY GIVE MY PERMISSION FOR

TO TAKE THE ABOVE PRESCRIPTION AT SCHOOL AS ORDERED. I UNDERSTAND THAT

IT IS MY RESPONSIBILITY TO FURNISH THIS MEDICATION AND MY CHILD'S

RESPONSIBILITY TO TAKE THE MEDICATION AS PRESCRIBED. ALL PRESCRIPTION

MEDICATION MUST BE GIVEN TO THE COUNSELOR. IT MAY NOT BE KEPT IN THE

STUDENT'S ROOM.

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

DATE

signature of parent

Name & Phone # of Emergency Contact _____

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