Achievement Centers for Children

THE ACHIEVEMENT CENTERS FOR CHILDREN

Emergency Transportation Authorization

Part I (Authorization) OR Part II (Refusal) must be completed

AUTHORIZATION

Name _____ D.O.B.__/__/__ Soc. Sec. # _____

Address _____

Mother (if minor) _____ Father (if minor)_____

Address _____ _____

_____ _____

Contact #_____ Contact # _____

Language spoken at home: _____ Insurance provider/ member ID# _____

In the event of reasonable attempts to contact me at my contact phone number have been unsuccessful, I hereby give consent for 1) the administration of any treatment deemed necessary by

my preferred doctor, Dr. _____ phone #_____

my preferred dentist, Dr. _____ phone # _____

or, in the event that the designated practitioner is not available, by another physician or dentist; and,

2) the transportation of myself/my child/my client to _____ Hospital, or to any hospital reasonably accessible.

In the event of an accident, injury or sudden illness, I give consent to and authorize The Achievement Centers for Children to summon a physician to perform medical treatment, transport to or request hospital admission or treatment billable to my insurance provider/member ID# as indicated previously and/or at my expense as may be necessary and for qualified personnel to perform necessary medical procedures.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the individual's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are noted on the Health History/ Physical Form.

Persons to be contacted in the event of an emergency if a parent/guardian cannot be reached (list two people):

Name	Name
Contact #	Contact #
Contact #	Contact #
Rel. to Client	Rel. to Client

ACCEPTANCE

Signed:_____ Rel. To Client _____ Date __/__/__

****

REFUSAL

I do not give consent for emergency medical treatment. In the event of illness or injury requiring emergency medical treatment, I understand that The Achievement Centers for Children must nevertheless act in the interests of health and safety and may need to call emergency personnel. I request that such personnel take no action until I or my legal designee can be contacted directly. I further understand that this form will be transported with me/my child/my client.

Signed:_____ Rel. to Client _____ Date __/__/__

Achievement Centers for Children

THE ACHIEVEMENT CENTERS FOR CHILDREN
Camp Cheerful
Authorization to Release Client

Do you give authorization to release client _____
(please print client name)

to someone other than a parent or guardian?

☐ No

☐ Yes

Please sign and return this form. If you responded yes, you must also complete the information below.

I, (please print name) _____, **parent/guardian** of the above named client, authorize the Achievement Centers for Children to release the above client to the individuals listed below for the purpose of being able to pick up in the event that I am unable to do so.

I understand that the individuals listed must be at least 18 years of age and may be asked for a picture identification by any staff at any time before the client will be released. I understand and agree that staff may refuse to authorize a release, if in their best professional judgment, circumstances warrant such refusal.

	Name	Phone number	Relationship to Client
1.			
2.			
3.			

I understand this authorization expires 360 days from the date it is signed unless otherwise indicated by me. I also understand that I may cancel this release at any time in writing with my signature, and the date it is signed, and deliver it to the Quality Assurance Manager/Privacy Officer. Canceling applies to that day forward and not to past occurrences.

Signed: _____ Date __/__/__

Relationship to Client_____

Achievement Centers for Children

Office Use Only

Initials _____

Achievement Centers For Children (ACC)
Recreation Department Authorization Release

Client Name: _____ (please print)

I, _____ understand that by giving a 'yes' permission
(Client, Parent, Guardian – please print)

below that I authorize the ACC the use of the my/my child's picture, voice, or demographic information in print or non-print materials.

PLEASE CHECK THE APPROPRIATE BOX BELOW:

☐ **YES**, I give permission to use in print and non-print materials including but not limited to: Brochures, Newsletters, Annual Report, Program Flyers, Miscellaneous publications, Public Service Announcements, Films, Audio tapes, Video tapes, Advertisements, Commercials, Websites, Webcasts, Streaming, Broadcasts (Radio and Television, including cable and satellite transmissions), agency social media sites (ie: Facebook page, Flickr, YouTube, etc.)

I release ACC, its personnel and any other persons making or handling the records from any liability.

I understand this release is good for the life of the print material and/or non-print material.

I understand that I have the right to revoke/withdraw this consent at any time in writing with my signature and giving it to the Development Department. My revocation/withdrawal will be effective except to the extent that ACC has taken action in reliance on my authorization.

☐ **NO**, I do **NOT** give permission for the ACC to use my/my child's picture, voice, or demographic information in print or non-print materials.

****

_____ _____

Client/Parent/Guardian Signature Date

Achievement Centers for Children

ACHIEVEMENT CENTERS FOR CHILDREN

AUTHORIZATION FOR RELEASE OF INFORMATION

Form Expires on_____

_____

Client's Full Name | Date of Birth

_____

Social Security Number | Individual Case Number (optional)

The following persons/programs/agencies have my permission to coordinate service planning and delivery for the above named person by disclosing specific information for the following specific purpose (s).
service coordination, assessment, treatment, and planning only with Achievement Centers for Children staff

Please identify all persons/programs/agencies that may disclose to and/or receive information.

- ❑ Achievement Centers for Children Team
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

I authorize the release of the specific information for which I have circled and initialed below only if it is necessary to secure or coordinate needed services identified in my case plan by the persons/programs/ agencies identified above:

Circle yes and initial

yes _____Identifying information: name, birth date, sex, race, address and telephone number.

yes _____Social Security Number

yes _____General Medical: medical records (except for HIV, AIDS and drug and alcohol treatment records) disability, type of services being received and name of agency providing services to me or the individual named above.

yes _____Social History: social history, treatment/service history, psychological evaluations and other -personal information regarding the individual named above or me.

yes _____School Information: grades, attendance records, Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), Individualized Service Plan (ISP), Multi-Factored Evaluation (MFE), (Children's) Ohio Eligibility Determination Instrument (COEDI/OEDI), transition plans and vocational assessments regarding me or the individual named above.

yes _____HIV and AIDS related diagnosis and treatment.

yes _____Current substance abuse treatment, recommendations and involvement specifically,

_____

yes _____Financial Information necessary to establish eligibility for public assistance including but not limited to pay stubs, W2's and tax returns, and other financial information.

yes _____Other

Revised 2/03 / 1821;revised 2/11;1/13

SIGNATURE REQUIRED ON BACK

I understand that my alcohol and drug abuse patient records are protected under the Federal regulations governing confidentiality of those records, (42 CFR Part 2), cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may inspect or copy the protected health information to be used or disclosed. I understand this Release expires 180 days from the date it is signed unless otherwise indicated by me. I also understand that I may cancel this Release at any time in writing with my signature, and the date it is signed, and delivering it to the Director of Quality Assurance/Privacy Officer. Canceling it applies to that day forward and not to information already shared.

I understand that signing or refusing to sign this Release will not affect public benefits or services for which I am eligible, unless otherwise required by the regulations of the agency.

I understand that the information disclosed pursuant to this authorization may be the subject of re-disclosure by the recipient without further protection.

If not previously revoked, this consent expires on the _____day of_____, 20_____.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness/Agency Representative Date

Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

TO ALL AGENCIES SENDING AND/OR RECIEVEING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

2. If the records released include information of an HIV-related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

3. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, Juvenile Court/DYS in the case of youth records, or applicable federal and/or state law.

Achievement Centers for Children

Challenge Course Release, Waiver, and Assumption of Risk Agreement

The undersigned hereby releases and discharges Achievement Centers for Children, and any of its employees, agents, heirs, successors and assigns (collectively, "Achievement Centers"), from any and all claims, damages, expenses, or lawsuits, of whatever nature, that arise from or relate in any manner to the participation in activities that occur at any property owned or operated by Achievement Centers within the State of Ohio (the "Property"), including participation in Achievement Centers' Low and High Ropes programs ("High Ropes Activities"), by the minor or mentally disabled adult participant named below.

The undersigned further agrees and acknowledges that this Release, Waiver, and Assumption of Risk Agreement ("Release") is applicable regardless of whether any claimed damage, expense, or injury results from the negligence of the Achievement Centers, or from some other cause. The undersigned hereby warrants and represents that he or she is in fact the legal parent or guardian of the minor or mentally disabled adult participant named below, with full rights of custody and control, has the authority to sign this Release on behalf of such minor or mentally disabled adult participant, and consents to that minor or mentally disabled adult's participation in activities at the Property, including participation in the High Ropes Activities.

The undersigned hereby acknowledges that he or she has full and complete notice and understanding of all the risks inherent in the High Ropes Activities that may cause, contribute to, or result in death or personal injury to the undersigned or damage to the undersigned's property (the "Risks"), including (a) exhaustion, fatigue, or serious injury caused by the physical, emotional, and mental exertions associated with strenuous physical activities and the expenditure of energy; and (b) serious physical injuries caused by falls or other physical contact, including bruises, broken bones, dislocated joints, injured muscles, head injuries, brain trauma, eye injuries, back injuries, paralysis, and even death. The undersigned specifically acknowledges that High Ropes Activities are conducted up to 50 feet above the ground, involve a number of strenuous exercises to be performed by participants before climbing, while climbing, and after they have climbed the High Ropes Course elements. The undersigned further acknowledges that he or she is in the best position to understand and evaluate the ability to participate in High Ropes Activities, including any added risk caused by any disability, illness, or condition, of the minor or mentally disabled adult participant.

Although the undersigned is aware of the nature and extent of the Risks, he or she expressly accepts and assumes all risks of property damage, bodily injury, and/or death that may occur as a result of the participation in High Ropes Activities at the Property by the minor or mentally disabled adult participant named below. This Release is given in specific consideration of the permission granted by the Achievement Centers to the minor participant to participate in High Ropes Activities at the Property.

The undersigned agrees to indemnify and save the Achievement Centers harmless from any and all medical bills, judgments, damages, or expenses associated with any claims, demands, or lawsuits made against the Achievement Centers, by or on behalf of any person, that arise as a result of the participation in High Ropes Activities at the Property by the minor or mentally disabled adult participant named below.

The undersigned states that he or she knowingly and voluntarily executed this Release and asserts that he or she understands all the terms used herein and the consequences thereof. The undersigned further acknowledges that this Release is binding upon the heirs, administrators, executors, successors and assigns of the undersigned and the minor or mentally disabled adult participant named below. This Release shall remain valid until revoked in writing by the undersigned.

Signed this ___ day of _____, 20___.

_____
Name of participant, please print

_____
Signature of participant

_____
Parent/Guardian signature (if participant is a minor or an adult with a developmental disability)

_____
Date of birth/social security number (if participant is a minor or an adult with a developmental disability)

Achievement Centers for Children

Equine Activity Release, Waiver, and Assumption of Risk Agreement

This Equine Activity Release, Waiver, and Assumption of Risk Agreement is given under the Ohio Equine Activity Liability Act (the "Act"). The undersigned hereby releases and discharges Achievement Centers for Children, and any of its employees, agents, heirs, successors and assigns, including any "equine professional" as defined by the Act (collectively, "Achievement Centers"), from any and all claims, damages, expenses, or lawsuits, of whatever nature, that arise from or relate in any manner to the participation in equine activities that occur at any property owned or operated by Achievement Centers within the State of Ohio (the "Property") by the minor or mentally disabled adult participant named below.

The undersigned further agrees and acknowledges that this Equine Release, Waiver, and Assumption of Risk Agreement ("Release") is applicable regardless of whether any claimed damage, expense, or injury results from the negligence of the Achievement Centers, or from some other cause. The undersigned hereby warrants and represents that he or she is in fact the legal parent or guardian of the minor or mentally disabled adult participant named below, with full rights of custody and control, has the authority to sign this Release on behalf of such minor or mentally disabled adult participant, and consents to that minor or mentally disabled adult's participation in equine activities at the Property. The undersigned further acknowledges that this Release is given on behalf of and is binding upon said minor or mentally disabled adult participant, his or her heirs, personal representatives, successors and assigns; and the undersigned further agrees that this Release shall also be as fully binding on the undersigned as if it were entered into solely on his or her own behalf.

The undersigned hereby acknowledges that he or she has full and complete notice and understanding of all the risks inherent in equine activities which may cause, contribute to, or result in the death or personal injury of the minor or mentally disabled adult participant or damage to the participant's property (the "Risks"), including: (a) the propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine; (b) the unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals; (c) hazards, including, but not limited to, surface or subsurface conditions; (d) a collision with another equine, another animal, a person, or an object; (e) the potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including, but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant. The undersigned further acknowledges that he or she is in the best position to understand and evaluate any added risk caused by any disability, illness, or condition of the minor or mentally disabled adult participant.

Although the undersigned is aware of the nature and extent of the Risks, he or she expressly accepts and assumes all risks of property damage, bodily injury, and/or death that may occur as a result of the participation in equine activities at the Property by the minor or mentally disabled adult participant named below. This Release is given in specific consideration of the permission granted by the Achievement Centers to the minor participant to participate in equine activities at the Property.

The undersigned agrees to indemnify and save the Achievement Centers harmless from any and all judgments, damages, or expenses associated with any claims, demands, or lawsuits made against the Achievement Centers, by or on behalf of any person, that arise as a result of the participation in equine activities at the Property by the minor or mentally disabled adult participant named below.

The undersigned states that he or she knowingly and voluntarily executed this Release and asserts that he or she understands all the terms used herein and the consequences thereof. The undersigned further acknowledges that this Release is binding upon the heirs, administrators, executors, successors and assigns of the undersigned and the minor or mentally disabled adult participant named below. This Release shall remain valid until revoked in writing by the undersigned.

Signed this ___ day of _____, 20___.

_____
Name of participant, please print

_____
Signature of participant

_____
Parent/Guardian signature (if participant is a minor or an adult with a developmental disability)

_____
Date of birth/social security number (if participant is a minor or an adult with a developmental disability)

Achievement Centers for Children

ACHIEVEMENT CENTERS FOR CHILDREN

Waiver of Liability for Adapted Aquatics/Swimming

Participant: _____
(please print)

I recognize there are risks inherent in the activity of swimming. In consideration for my/my minor child's/an adult with a developmental disability's participation in the Achievement Centers for Children pool, I, the undersigned, hereby fully and forever waive, release, and discharge, for myself, the participant, my estate, my heirs, executor, and assigns, the Achievement Centers for Children, and any of its trustees, officers, administrators, employees, agents or volunteers, or any other persons or entities involved in the planning, organization, supervision, or any other aspect of the pool or related activities, including the use of the facilities or properties of any such persons or entities, from any and all losses, damages, or claims whatsoever, including any and all personal injuries or damages, arising directly or indirectly from usage of the pool or related activities, whether said losses, all damages, or claims are caused directly or indirectly, by or related to a known or unknown risk or hazard, and whether they are caused by a negligent act or acts. By signing I warrant that I have read and understand the contents and meaning of the release and waiver or right to sue and agree to be legally bound by all of its terms and conditions. This waiver shall remain valid until revoked in writing by the undersigned.

_____ _____
Participant signature (if own legal guardian) Date

_____ _____
Parent/Guardian signature (if participant is a minor or participant has a guardian) Date

2/5/14 RL

The Achievement Centers for Children

Recreational Programs

PICK UP and EXTENDED CARE POLICY

WEEKEND RESPITE PROGRAM (September through April sessions) – Pick up time for a **two-night session** is Sunday at 2:00 pm. All clients must be signed out with the program staff and off the premises by 2:30 pm. For every ten minutes after 2:30 pm, an additional $10 will be charged (i.e., pick up at 3:00 pm and the charge will total $30.00).

RESIDENT CAMP (Summer) - Pick up time at the conclusion of a resident session is at 11:00 am. All clients must be signed out with the program staff and off the premises by 11:30 am. For every ten minutes after 11:30 am, an additional $10 will be charged (i.e., pick up at 12:00 pm and the charge will total $30.00).

DAY CAMP and CHAMP CAMP (Summer) - Pick up time is Monday through Friday at 4:00 pm (unless registered for extended care in Strongsville). All clients must be signed out with the program staff and off the premises by 4:15 pm. If a client is picked up after 4:15 pm, they will be charged the extended care fee for the week which is $55.00.

EXTENDED CARE (Summer for Day Camp) – Cheerful Day Camp in Strongsville offers an extended care program. Due to parents' work schedules, emergencies, etc., we offer extended care services at 7:30-9:00 am and also at 4:00-6:00 pm. The fee is $55.00 per week whether the service is used in the morning, evening, or both. Clients cannot be signed in prior to 7:30 am. Clients must be signed out with the program staff and off the premises by 6:00 pm. For every ten minutes after 6:00 pm, an additional $10.00 will be charged (i.e., pick up at 6:30 pm and the charge will total $30.00).

SENSATIONAL DAY PROGRAM (Summer) - Pick up time is Monday through Friday at 3:00 pm. All clients must be signed out with the program staff and off the premises by 3:15 pm. There is no extended care offered for this program. However, if a client is picked up after 3:15 pm, for every ten minutes after 3:15 pm, an additional $10 will be charged (i.e., pick up at 3:45 pm and the charge will total $30.00).

_____

Client Name (Print)

_____ Date: _____

Client / Parent / Guardian Signature