Lake George Charter School

2020-21
Signature and Information Page

Please sign and return all forms by August 3, 2020. Children will not be enrolled until **all** forms and fees are received.

- ☐ Student Enrollment Form
- ☐ Emergency and Alternate Contacts
- ☐ Educational History
- ☐ Proof of Residency
- ☐ Health Screening Questionnaire
- ☐ Allergy Health History Form
- ☐ Emergency Medical Authorization
- ☐ Media Release
- ☐ Permission for Medication
- ☐ Immunizations/Exemption
- ☐ Custody Agreement if necessary
- ☐ Supply Fee-$50 per child (Preschool has their own fee schedule)
- ☐ Student Handbook Review
- ☐ Waiver of Liability Relation to CORONAVIRUS/ COVID-19
- ☐ Dismissal Procedures
- ☐ We use the Flash Alert system to notify families of snow delays/closures. Please sign up today at www.FlashAlert.net/id/LGCS

______________________________ Parent Signature

______________________________ Date

Your signature indicates that you have received and understand the enclosed information.

For your convenience you have 3 options to return the forms.

Please print and email(or mail) all forms along with the supply fee to:

LGSCHOOL@LGCSCO.ORG

Mail to: PO BOX 420, Lake George, CO, 80827

Drop in the school drop box, by August 3, 2020

LAKE GEORGE CHARTER SCHOOL
Park County School District Re-2
Enrollment & Confidential Information Form

Date:________________________ Online:_______ Grade:________

Student's Name: ____ Sex: F or M
Last First Middle (Circle One)

Home Phone #:____

Mailing Address:____
PO Box/Street City Zip Code

Physical Address:____ County: ____________________
Street

School Dist. of Residence: Park County Re-2 Woodland Park Re-2 Cripple Creek/Victor Re-1

(Circle one)

Date of Birth: ____________________ Birthplace: ______________________________ Age as of Oct 1: _____
Month-Day-Year

Moved to Colorado: ____________ (if not born here)

Date

Mother's Name: ____ Occupation_________________________
Last First Middle

Home Phone:_________________________ Home E-mail:____

Cell #:_______________________

Place of Employment:_______________________________________ Location:_____________________________
City

Work Phone:_________________________ Work E-mail:____

Father's Name :____ Occupation:_________________________
Last First Middle

Home Phone:_________________________ Home E-mail:____

Cell #:_______________________

Place of Employment:_______________________________________ Location:_____________________________
City

Work Phone:_________________________ Work E-mail:____

With whom does student live: Father Mother Both Guardian(s) (Circle One)

Guardian's Name: ____ Phone:______________________

Guardian's Address:____

Student's Name: ____ Date: ____________
Last First Middle Int.

EMERGENCY AND ALTERNATE CONTACTS:

In the event, your child experiences illness or injury during school, **OR** you need to have someone other than yourself pick up your child, please list at least 2 contacts *(other than yourself)* who are ***ALLOWED*** to pick up your student if we are unable to reach a Parent/Guardian in case of an emergency.

1st Emergency Contact: ______________________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

2nd Emergency Contact: ______________________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

3rd Emergency Contact: ______________________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

4th Emergency Contact: ______________________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

5th Emergency Contact: ______________________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

6th Emergency Contact: ______________________________ Relationship: ______________

Home Phone ______________ Cell Phone: ______________ Work Phone: ______________

PLEASE NOTE: It is the responsibility of the parent or guardian to provide the school with *any* changes in phone numbers or emergency contacts. We CANNOT allow children to be taken from school by anyone other than a parent or guardian without written consent from the parent or guardian.

******** Sick children CANNOT remain at school under any condition. ********

******** Children who have been absent from school should NOT attend after school activities. ********

____
Parent/Guardian Signature

Student's Name: ____
Last First Middle Int.

EDUCATIONAL HISTORY:

Entered a Park County School: __________
Date

Last School Attended: ____
(If not in Park County Re-2)

Has student attended other schools in the past year? _______ Yes _______ No New to Educ.: __________

Where: ______________________________________ New to State: __________

(Please **check** those that apply to your child)

______ Attended preschool? Full Year ___ Partial Year ___
______ Attended kindergarten? Full Year ___ Partial Year ___
______ Missed more than ten days in a school year?
______ Retained a grade? If so, what grade? __________
______ Skipped a grade? If so, what grade? __________
______ Has your child been home schooled in the past? _______ Yes _______ No
For what grades? ______________
______ Difficulty with reading?
______ Difficulty with math?
______ Difficulty with writing?
______ Intense interest in a particular subject? If so, what subject ______________________
______ Dislikes going to school?
______ Do you have any concerns about your child's social skills? _______ Yes _______ No
______ Tested for Special Education in the past? If so, when? ______________________
______ Has student received special services? (i.e. special ed., title 1,)
Special Ed. _______ Yes _______ No
Title 1 _______ Yes _______ No
_____ Has a 504 plan been considered?
_____ Has a 504 plan been written?

Is the student currently expelled from another district/school? _______ Yes _______ No
*Please note a student cannot be enrolled if he/she is currently expelled from another school district.

GR	Name of School	City/State	Public/Private/ Charter School	Home Schooled?	School Years
PreK					
K					
1					
2					
3					
4					
5					
6					
7					
8					

Proof of Residency

AFFIDAVIT OF STATE OF COLORADO RESIDENCY

Pursuant to 1CCR301-71, Rules for the Administration, Certification and Oversight of Colorado Online Programs, the Colorado State Board of Education must ensure that student residency is documented and verified, both upon initial enrollment and annually thereafter. Colorado residency is determined by the student and Parent or legal guardian currently residing within the State of Colorado boundaries, except for students of military families that maintain Colorado as their state of legal residence for tax and voter registration purposes. Reasonable evidence of residency within the State of Colorado boundaries can be established by a written statement of residency from the student's parent/guardian pursuant to Section 8.06.4:

Please complete all required fields (*) in order to evidence Colorado residency for those students listed below for purposes of residency status for the Colorado Department of Education. Failure to complete all required fields (*) will result in an invalid/incomplete Affidavit. ***We also need a copy of a utility bill or mortgage bill with the physical address on it.***

++

Affidavit by Parent or Legal Guardian:

*Name of Person Completing this Affidavit: ______________________________

*Relationship to student(s) listed below:

_______ Parent

_______ Legal Guardian

If Online student, name of Online School/Program: Virtual Village-Lake George Charter School-Acellus

Student:______________________________ Grade:__________

*Physical address (cannot be a post office box or general delivery at a post office) for all students listed above:

Address: ____

Street (Physical) Apt. #

____

City County State Zip

*I do hereby swear and affirm, under penalty of perjury, that my child, as listed above, and I are/will be residents of the State of Colorado for the **2020/2021** school year.*

***Parent/Guardian Signature:** ______________________________ ***Date:** __________

LAKE GEORGE CHARTER SCHOOL
SCHOOL HEALTH SCREENING QUESTIONNAIRE

Name of Child: ____
Last First Middle

Date of Birth: ____________________ Grade: ______________ Date: ____________________

Name of person filling out questionnaire: ____

Relationship to student: ________________________________

1. When has this child last had a routine health exam? Date: ____________________

2. Has there ever been a concern about the age at which your child began: (Please write "yes" or "no" beside each developmental milestone.)
   Crawling__________ Walking__________ Talking________ Bowel and Bladder Training____________

   If yes, please explain: ____
   ____

Please check appropriate blank:

3. Are there any major health problems in the family? No_____ Yes_____
   If yes, please comment:
   ____
   ____

4. Child's Health History:
   Check any of the following that apply to child's health history.

Psychiatric Disorder (including anxiety / depression)	No_____	Yes_____
Liver Disease (i.e. Hepatitis)	No_____	Yes_____
Headaches/Migraines	No_____	Yes_____
Diabetes	No_____	Yes_____
Neurological Disorder (seizures)	No_____	Yes_____
Renal Disease (Kidney)	No_____	Yes_____
Cancer	No_____	Yes_____
Respiratory Disease (including asthma / Reactive Airway Disease)	No_____	Yes_____
Skin / Dermatological Disorder	No_____	Yes_____
Cardiac Disorder / Hypertension / Cholesterol	No_____	Yes_____
Immune suppressed	No_____	Yes_____
Gastrointestinal Disorder	No_____	Yes_____
Allergies (Please see Allergy Health History Form)	No_____	Yes_____
Other ______________________________	No_____	Yes_____

   If yes, (a) is he/she still under treatment? No_____ Yes_____
   (b) can the school health service be helpful? No_____ Yes_____
   If yes, please comment:
   ____
   ____

5. Has your child had any serious illness, operations, or injury? No_____ Yes_____
   If yes, (a) is he/she still under treatment? No_____ Yes_____
   (b) can the school health service be helpful? No_____ Yes_____
   If yes, please comment:
   ____
   ____
   ____

6. Has your child had any problem with vision? No_____ Yes_____
   Does your child wear glasses? No_____ Yes_____
   Has your child had any problem with hearing? No_____ Yes_____
   If yes, please comment:

   ____
   ____

7. Is your child on medication? No_____ Yes_____
   If yes, please state medication:

   ____

   Does it need to be given in school? No_____ Yes_____
   If yes, this requires a 'Permission to Administer Medication' form.

8. Does your child have any disabilities? Any limitations? No_____ Yes_____
   If yes, please comment:

   ____
   ____

9. Does your child have any need for special attention because of health problems? No_____ Yes_____
   If yes, please comment:

   ____
   ____

10. Does your child have sleeping or bedtime concerns? No _____ Yes _____ Explain: ______________________
    Does your child have a limited attention span? No _____ Yes _____
    Do you think your student is distractible? No _____ Yes _____
    Is your student impulsive? No _____ Yes _____

11. Has this child ever experienced any parental separations, divorces, or death? No _____ Yes _____
    If yes, which? ______________________ Age of child at the time: ______________
    Please describe circumstances: ____
    ____
    ____

    If parents are separated or divorced, How often does child see the other parent? ______________
    Is there anything significant about the visits? No _____ Yes _____ Explain: ______________
    ____

12. **Is there anything else about your child you would like to tell us?** No _____ Yes _____
Explain: ____
____
____
____
____
____

Allergy Health History Form

Student Name: ____________________ Date of Birth: ____________ Grade: ______

Parent/Guardian: ____________________ Today's Date: ____________

Home Phone: ____________ Work: ____________ Cell: ____________

Primary Healthcare Provider: ____________________ Phone: ____________

Allergist: ____________________ Phone: ____________

1. Does your child have a diagnosis of an allergy from a healthcare provider? ☐ No ☐ Yes
2. History and Current Status

a. What is your child allergic to?

☐ Peanuts ☐ Insect Stings
☐ Eggs ☐ Fish/Shellfish
☐ Milk ☐ Chemicals ____________
☐ Latex ☐ Vapors ____________
☐ Soy ☐ Tree Nuts (walnuts, pecans, etc)
☐ Other: ____________

b. Age of student when allergy first discovered: ______

c. How many times has student had a reaction:
☐ Never ☐ Once ☐ More than once, explain:
____

d. Explain their past reaction(s): ____________

e. Symptoms: ____________

f. Are the allergy reactions: ☐ Same ☐ Better ☐ Worse

3. Trigger and Symptoms

a. What are the early signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say.) ____________
____

b. How does your child communicate his/her symptoms? ____________

c. How quickly do symptoms appear after exposure? ______ secs. ______ mins. ______ hrs. ______days

d. Please check the symptoms that your child has experienced in the past:

Mouth: ☐ Itching ☐ Swelling (lips, tongue, mouth)
Abdominal: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea
Throat: ☐ Itching ☐ Tightness ☐ Hoarseness ☐ Cough
Lungs: ☐ Shortness of breath ☐ Wheezing ☐ Repetitive Cough
Heart: ☐ Weak Pulse ☐ Loss of Consciousness
Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling (face, hands, etc)

4. Treatment

a. How have past reactions been treated? ____________

b. How effective was the student's response to treatment? ____________

c. Was there an emergency room visit? ☐ No ☐ Yes, explain: ____________
____

d. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: ____________
____

e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? ______
____

f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

g. Have you used the treatment or medication? ☐ No ☐ Yes

h. Please describe any side effects or problems your child had in using the suggested treatment: ____________

5. Self Care

a. Is your student able to monitor and prevent their own exposure? ☐ No ☐ Yes
b. Does your student:
   1. Know what triggers to avoid ☐ No ☐ Yes
   2. Ask about ingredients ☐ No ☐ Yes
   3. Read and understand labels ☐ No ☐ Yes
   4. Tell an adult immediately after an exposure ☐ No ☐ Yes
   5. Wear a medical alert bracelet, necklace, watchband ☐ No ☐ Yes
   6. Tell peers and adults about the allergy ☐ No ☐ Yes
   7. Firmly refuses a problem food/trigger ☐ No ☐ Yes
c. Does your child know how to use emergency medication? ☐ No ☐ Yes
d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. Family / Home

a. How do you feel that the whole family is coping with your student's allergies? ______
b. Does your child carry epinephrine in the event of a reaction? ☐ No ☐ Yes
c. Has your child ever needed to administer that epinephrine? ☐ No ☐ Yes
d. Do you feel that your child needs assistance in coping with their allergy? ☐ No ☐ Yes, explain: ______

______

7. General Health

a. How is your child's general health other than having an allergy? ______
b. Does your child have other health conditions? ______
c. Hospitalizations? ______
d. Does your child have a history of asthma? ☐ No ☐ Yes
   If yes, does he/she have an Asthma Action Plan? ☐ No ☐ Yes
e. Please add anything else you would like the school to know about your child's health: ______

______

______

8. Notes:

Parent / Guardian Signature: ______ Date: ______

Reviewed by R.N.: ______ Date: ______

EMERGENCY MEDICAL AUTHORIZATION

Student: ______________________________ Date of Birth: ______________ Grade: ________

Address: ______________________________ City ________________ State _____ Zip ________

RESIDENTIAL PARENT OR GUARDIAN: ______________________________

Phone: Home ________________ **Work** ________________ **Cell** ________________

2nd Contact ________________ Phone: Home ____________ Work ____________ Cell ____________

3rd Contact ________________ Phone: Home ____________ Work ____________ Cell ____________

4th Contact ________________ Phone: Home ____________ Work ____________ Cell ____________

<u>Purpose</u> – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Please list facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

- ☐ **Medications taken at home and/or at school** ______________________________
- ☐ **Allergies** ______________________________
- ☐ **Medical Conditions** ______________________________
- ☐ **Surgeries** ______________________________

____

PART I OR II MUST BE COMPLETED

Part I – To Grant Consent

I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor ____________________ Phone Number ____________________

Dentist ____________________ Phone Number ____________________

Medical Specialist ____________________ Phone Number ____________________

Local Hospital ____________________ Emergency Room Phone ____________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to any hospital reasonably accessible.

____

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

______________________________ ____________________

Signature of Parent/Guardian Date

____

Street Address City State Zip

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I <u>DO NOT</u> GIVE CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

____

____________________ ______________________________

Date Signature of Parent/Guardian

____

Street Address City State Zip

Lake George Charter School

38874 US Hwy 24
PO Box 420
Lake George, CO 80827-0420
Phone: 719-748-3911 Fax: 719-748-8151

MEDIA RELEASE FORM

At times during the school year, school personnel and/or the news media may ask to interview and/or photograph students. While we enjoy having school events publicized, we respect your right as a parent to decide whether or not to have your child participate in an interview, have his/her picture in the newspaper or on the school website. Please indicate whether you agree to have your child's photograph or interview by completing the form below and returning it to the school office.

Please check one box only:

- ☐ I hereby give permission to allow my child to be photographed and/or interviewed by the media. I agree to allow my child to participate in media projects without financial remuneration, and I understand that this releases the school/District from any future claims, as well as from any liability, arising from the use of the said interview/photograph.

- ☐ I **DO NOT** grant permission for the school/internet/news media to take or use any interview/photograph of my child.

- ☐ I hereby give permission to allow my child's photo to be used by the media only **IF** the photo is a group shot where individual children are not identified.

Name of Child: ______________________________

Address: ______________________________

City, State, ZIP: ______________________________

Signature of Parent or Guardian: ______________________________

Phone: ____________________ Date: ____________________

NOTE: All of the students attending LGCS will be in the annual yearbook which is available for purchase at the end of each school year. At any time during the school year, you may amend this form for future uses/preferences by notifying the office in writing of your request.

(Rev. 4-16-2018)

PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

TO BE COMPLETED BY HEALTH CARE PROVIDER
(FOR PRESCRIPTION or OVER-THE-COUNTER MEDICATION)

(Complete one form per medication; prescription or over-the-counter medication.)

Name of Student: ______________________________ **Date of Birth:** ______________

Medication: ______________________ **Reason for medication:** ______________________

Dosage: ________________ **Route:** ________________ **Time:** ________________

Please list specific dosage, such as 2 tab/tsp/puffs every 4 hours, not a range such as 1-2 tab/tsp/puffs every 4-6 hours.

If 'as needed' (PRN), indicate when dose can be repeated: ______________________

Special Instructions: ____

Possible Side Effects: ____

Start Date: ______________________ **End Date:** ______________________

Name of Health Care Provider (print): ______________________ **Date:** ______________

Signature of Health Care Provider with Prescriptive Authority: ______________________

Office Phone Number: ______________________ **Fax:** ______________________

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that whenever possible, medication should be administered at home. I understand that it is my responsibility to furnish the medication to school in the original container marked with my child's name. Any prescription changes will require an additional signed and completed 'Permission to Administer Medication' form.

I give my permission for the school staff to contact the prescribing physician regarding this medication. I understand that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Lake George Charter School, the undersigned parent or guardian agrees to release Lake George Charter School and it's personnel from any legal claim which he, she or their child may now have or may hereafter have arising out of side effects or other medical consequences of the medication. I hereby give my permission for the student named above to take the above medication at school as ordered.

Name of Parent/Guardian (print): ______________________________________

Home Phone: ________________ **Work Phone:** ________________ **Cell Phone:** ________________

Signature of Parent/Guardian: ______________________________ **Date:** ______________

Lake George Charter School
Park County School District RE-2

SUPPLY FEE

K-5 Yearly Supply Fee: = $50.00

(This does not apply to the preschool)

*unable to accept credit cards at this time.

Date ______________

Student's Name __________________________________ Grade ______________

Amount Paid __________

Parent/Guardian Signature ____

For Office Use

Amount Paid _________ Cash _____ Check # _______ MySchoolBucks ______

Lake George Charter School

38874 US Hwy 24
PO Box 420
Lake George, CO 80827-0420
Phone: 719-748-3911 Fax: 719-748-8151

Date: ____________________

Dear Parent/Guardian:

Please review the Lake George Charter School Student Handbook with your child. Sign below and return this form with your enrollment packet. Thank you.

My child, ____, and I have reviewed and understand the Student Handbook for the 2020-2021 school year.

____
Student Signature

____
Parent/Guardian Signature

Lake George Charter School

Park County School District RE-2

DISMISSAL PROCEDURES

The dismissal bell rings at 4:00. You have been/will be issued a number that represents your family. When you arrive at the school, a staff member will radio in your number, signaling your child to leave the school. You are welcome to wait in the foyer or outside the front doors. You may also stay in your car and use the carpool lane. Display your family number in your window and move forward when instructed. Children must enter the car through the passenger side. Please ***DO NOT*** exit your vehicle. If you need to help your child in any way, eg: buckling into a car seat, please park in the lot and pick up your child at the door. On most days, the line of cars extends out onto Hwy 24, so we need to keep the line moving quickly and safely!

If you have not arrived to pick up your child by 4:15, we will begin calling you / your designated emergency contacts, for someone to come for your child. If no one has arrived by 4:30, or made arrangements for a staff member to stay after hours, at a cost to the parent, law enforcement may be notified to pick up your child. The cost to late parents will be $20 for pickup between 4:31-5:00, and another $20 between 5:01-5:30, etc. This also applies to half hour intervals following Landsharks and YES club.

Kindly,

Zoe Ann Holmes

Administrator
719-748-3911 ext. 104 - office

Assumption of the Risk and Waiver of Liability Relating to CORONAVIRUS/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely dangerous** and is believed to be spread from person-to-person contact. As a result, federal, state, and local governments and health agencies recommend established guidelines to reduce the risk of spreading the virus. These include requiring social distancing and, in many locations, prohibiting the congregation of large groups of people. These guidelines are for the safety of the public and should be followed.

Notwithstanding recommendations and guidelines by these entities, it must be understood that COVID-19 is a continuing threat to the health and lives of the citizens of Colorado.

Lake George Charter School has put in place preventative measures to reduce the spread of COVID-19. However, it is understood that Lake George Charter School cannot guarantee that you will not come into contact with or become infected with COVID-19. Your mere physical presence at Lake George Charter School could **increase your risk** of contracting the disease.

Notwithstanding the risk of infection, I wish to voluntarily participate in on-campus learning offered by Lake George Charter School.

In consideration of being allowed to participate in on-campus learning and related events and activities, I hereby freely, voluntarily, and without duress execute this Release and agree to the following terms:

1. Assumption of Risk. I am aware and understand that although LAKE GEORGE CHARTER SCHOOL has taken precautions to provide proper organization, supervision, instruction, and precautions for the services being offered, it is impossible for LAKE GEORGE CHARTER SCHOOL to guarantee absolute safety from infection by COVID-19. I understand that participation in on-campus learning may expose me to infection.

2. Student Responsibilities. I am aware and understand that I share the responsibility for safety during all activities. I will inform my teachers of any questions or concerns regarding my understanding of safety standards, guidelines, and procedures. I will take steps to monitor my own health. I will not participate in on-campus learning if I am sick.

3. Waiver and Release. I hereby fully and forever release and discharge LAKE GEORGE CHARTER SCHOOL from, and expressly waive, any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, that may arise from my participation in on-campus learning. I assume all the foregoing risks

and accept personal responsibility for the damages due to such injury, permanent disability, or death resulting from participation in on-campus learning.

I UNDERSTAND THAT THIS RELEASE DISCHARGES LAKE GEORGE CHARTER SCHOOL FROM ANY LIABILITY OR CLAIM THAT I MAY HAVE AGAINST LAKE GEORGE CHARTER SCHOOL WITH RESPECT TO ANY BODILY INJURY, PERSONAL INJURY, ILLNESS, DEATH, PROPERTY DAMAGE, OR PROPERTY LOSS THAT MAY RESULT FROM ON-CAMPUS LEARNING, WHETHER CAUSED BY THE NEGLIGENCE OF LAKE GEORGE CHARTER SCHOOL OR OTHERWISE.

BY SIGNING BELOW, I EXPRESS MY UNDERSTANDING AND INTENT TO ENTER INTO THIS RELEASE WILLINGLY AND VOLUNTARILY. FURTHER, I CERTIFY THAT I AM FULLY COMPETENT AND HAVE THE FULL LEGAL AUTHORITY TO SIGN THIS AGREEMENT.

Signature of Student: ______________________________

Name of Student: ______________________________

Address: ______________________________

Date: ______________________________

If the student is under 18 years of age, a parent or legal guardian must also sign.

I AM THE PARENT OR LEGAL GUARDIAN OF THE MINOR STUDENT NAMED ABOVE AND I CERTIFY THAT I HAVE FULL LEGAL AUTHORITY AND CUSTODY OF STUDENT. ON BEHALF OF THE STUDENT NAMED ABOVE, I HEREBY AGREE ON BEHALF OF STUDENT TO ALL OF THE WAIVERS, RELEASES, ACKNOWLEDGEMENTS OF RISK, AND CONDITIONS OF THIS AGREEMENT. I AUTHORIZE LAKE GEORGE CHARTER SCHOOL TO OBTAIN MEDICAL TREATMENT.

Signature of Parent or Legal Guardian: ______________________________

Name of Parent or Legal Guardian (please print): ______________________________

Address: ______________________________

Date: ______________________________

EMERGENCY CONTACT INFORMATION

In case of an emergency, contact:

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Telephone Number: ______________________________

Email: ____

Any allergies, medications, or other information needed in an emergency:

____