Application for Admission

- ***Please include an application fee of $200.00 and a recent photo of the applicant with this application.***

Applicant's Name____ ☐ M ☐ F
Last First Middle

Address ____

City/State/Zip ____

Telephone (____) _______________ Soc. Sec. # __________________D.O.B.___/___/_____ Age ____

Ethnicity ________________Height _______Weight _______ Eye Color _______Hair Color ________

Birth Place _____________________ Was Applicant Adopted? ☐ Yes ☐ No If yes, at what age _____

Name of Adoptive Parent ____

Are parents divorced? ☐ Yes ☐ No Date _________ If so, who has legal custody?* _______________

Please submit a copy of the court order relating to custody of applicant with this application. Custodial parent (s) must sign where parental signature is required.

Case # ______________________ Jurisdiction (State & Cty.) __________________________________

Who referred you to us? ____

In case of an emergency notify:
Name Relationship Address Phone Home/Work

____

____

____

Financial Sponsor ____________________________________Telephone (____) __________________

Address ____

City/State/Zip ____

Parent/Guardian's Name ____Date __________

Signature ____

Parent/Guardian's Name ____Date __________

Signature ____

Exploration, is an independent, non denominational educational program and does not discriminate against applicants on the basis of race, religion, sex, color or ethnic origin.

Explorations
Self Discovery through Personal Challenge

Parent Information

Please fill out as completely as possible even if both of the parents are deceased

Father

____
Last First MI

Home Address _______________________________

____

City _______________________________________

State ____________________________Zip_________

Home Phone _________________________________

Fax ___________________________ ☐ Home ☐ Work

Business Phone ______________________________

Cell Phone/Pager _____________________________

E-mail _____________________________________

Employer ___________________________________

Occupation _________________________________

Social Security Number ________-_______-________

If applicable, date of death ____________________

Mother

____
Last First MI

Home Address _______________________________

____

City _______________________________________

State ____________________________Zip_________

Home Phone _________________________________

Fax ___________________________ ☐ Home ☐ Work

Business Phone ______________________________

Cell Phone/Pager _____________________________

E-mail _____________________________________

Employer ___________________________________

Occupation _________________________________

Social Security Number ________-_______-________

If applicable, date of death ____________________

Step Father

____
Last First MI

Home Address _______________________________

____

City _______________________________________

State ____________________________Zip_________

Home Phone _________________________________

Fax ___________________________ ☐ Home ☐ Work

Business Phone ______________________________

Cell Phone/Pager _____________________________

E-mail _____________________________________

Employer ___________________________________

Occupation _________________________________

Social Security Number ________-_______-________

Date of Marriage ____________________________

If applicable, date of death ____________________

Step Mother

____
Last First MI

Home Address _______________________________

____

City _______________________________________

State ____________________________Zip_________

Home Phone _________________________________

Fax ___________________________ ☐ Home ☐ Work

Business Phone ______________________________

Cell Phone/Pager _____________________________

E-mail _____________________________________

Employer ___________________________________

Occupation _________________________________

Social Security Number ________-_______-________

Date of Marriage ____________________________

If applicable, date of death ____________________

Family Information

- ***List applicant and all siblings, step and half-siblings of the applicant in chronological order. Please note if any siblings are deceased.***

Name	Sex	Age	DOB	Current Residence	Biological/Adopted

Please list additional; siblings on a separate sheet of paper

Applicant Information

Please list all counselors and therapists who have seen applicant

Psychiatrist/Therapist Name ____

Nature of Service ______________________________ Phone # ______________

Address ______________________________________ E-mail ________________

Date seen __________ Reason ____________________ Treatment Diagnosis ______________

Psychiatrist/Therapist Name ____

Nature of Service ______________________________ Phone # ______________

Address ______________________________________ E-mail ________________

Date seen __________ Reason ____________________ Treatment Diagnosis ______________

Please list any additional names on a separate sheet of paper

If the applicant has ever been placed outside of the natural home, please list placement. Include boarding schools, foster homes, hospitals, etc.

Placement	Date	Reason for Placement

If the applicant is on probation, please provide Probation Officer's name, address and phone number.

Name ____ Phone ________________

Address ______________________________________ E-mail________________

City/State/Zip ____

Reason for Probation/Dates____

____

Explorations
Self Discovery through Personal Challenge

Applicants Personal History

• ***The following questions are designed to assist us in working most effectively with your child and your family. You may continue your answers on additional paper if necessary.***

List the positive qualities, interests and accomplishments of applicant:

____

____

____

____

Has applicant experienced any traumatic major loss or substantial changes in his/her life?

____

____

____

____

What areas do you see as applicant's strengths/weaknesses?

Strengths: ____

____

Weaknesses: ____

____

Describe applicant's relationship with each parent and/or step-parents, siblings and any other significant relationship(s):

____

____

____

____

____

____

____

____

____

____

____

____

____

From your point of view, what are applicant's most serious problems? How and when did they begin?

____

____

____

____

What are your reasons for applicant's participation in an Explorations program? (Include behavior problems such as dishonesty, stealing, manipulation, conflict, etc.

____

____

____

____

What results are you seeking from this program? ____

____

____

____

- ***Has the applicant ever experienced or exhibited any of the following? If yes, Please describe.***

Fire setting ____

____

Drug, alcohol or nicotine-if yes, quantity: ____

____

____

Suicide discussion, thoughts and/or attempts: ______________________________________

____

____

____

Assaultive behavior/physical aggression: ____

____

____

____

Sexual or physical abuse ____

____

____

Sexual acting-out promiscuity, inappropriate sexual behavior, rape: ______________________________

____

____

____

Self-abusive behavior/mutilation (include tattoos and body piercing): _____________________________

____

____

____

Runaway history or potential – if yes, who is applicant most likely to contact? ______________________

____

____

____

Problems with the law: ____

____

____

____

Eating disorders and/or body image problems ____

____

____

____

Family Dynamics:

Name any significant family member(s) or friends who are deceased. Please describe circumstances, including date of death and applicant's reaction.

____

____

____

____

Please describe any areas of conflict in your current family (marital, parent/child conflict, etc.):

____

____

____

____

____

What does applicant do when upset or frustrated? ____

____

____

____

Is there any cultural/religious information we should know? _________________________________

____

____

____

Who is applicant's disciplinarian at home and how does applicant respond to discipline? ___________

____

____

____

School Involvement and Interaction:

In what grade level is the applicant currently enrolled? ______________________________________

____

How well does applicant get along with other children, adults and authority figures? _______________

____

____

Has applicant ever been given educational or psychological testing? If so when? _________________

____

____

Has applicant has school disciplinary problems/expulsion? If so explain: ________________________

____

____

____

Has applicant been held back a grade and/or withdrawn? ______________________________________

____

____

Has there been a change in school performance? If so when?_________________________________

____

____

Program & Activity Consent

Applicant's Name ____
Last First Middle

I understand that Explorations, HomeBase, Wilderness Assessment, Experiential Learning, Summer adventure, and Custom Venture programs are physically and emotionally challenging, and that activities may include, but are not necessarily limited to: kayaking, canoeing, camping, hiking, rock-climbing, rafting, horseback riding, downhill, telemark and cross-country skiing, sledding, bicycling, sailing, swimming, counseling, and school offered extra curricular activities. Programs and trips conducted by Explorations, including but not limited to those mentioned above.

I hereby release and discharge Explorations, its agents, employees, officers and directors from all claim, demands, actions, judgments and executions which the undersigned may have against Explorations, for all personal injuries known or unknown, and damage to property, personal or real, caused by or arising out of my child's or my family's participation in any Explorations, program or activity.

I understand that enrollment in Explorations, and all activities relating thereto is governed by the laws of the State of Montana. Any controversy or claim arising out of or relating to these terms, or the making, performing or interpretation thereof, shall be settled by binding arbitration in Helena MT, in accordance with the rules of the American Arbitration Association, then existing, and judgment on the arbitration award may be entered in any court having jurisdiction over the subject matter of the controversy.

I the undersigned have read this release and understand all of its terms. I execute it voluntarily and with the full knowledge of its significance.

I hereby authorize Penny James or any staff member of Explorations to provide authorization/confirmation emergency and/or medical treatment for applicant, at any medical facility, should it be deemed necessary. I understand this will be done on my behalf should Explorations be unable to contact me at the time of said emergency. I am ultimately responsible for payment of said treatment.

I understand and agree that applicant's personal affects and also his/her person may be searched at the discretion of Explorations personnel for the purpose of discovering any prescribed or non-prescribed drugs or medications or other items not permitted during participation in Explorations programs, and that all prescribed medications to be taken by the applicant throughout any Explorations program will be in the custody of, and dispensed by, Explorations personnel. I understand and agree that applicant may be tested for drug use with urinalysis screen, administered by a licensed physician and/or medical staff, at the discretion of Explorations personnel.

I ☐ do ☐ do not agree to have applicant photographed. I understand these photos may be used for presentation purposes.

Custodial Parent/Guardian ______________________________ ________________
Signature Date

Custodial Parent/Guardian ______________________________ ________________
Signature Date

Professional Release

Attach additional release information on a separate piece of paper, if necessary

I hereby authorize Explorations, to release information regarding the progress of:

____ to the following professional(s)
Name of Applicant

Name ____

Address ____

Telephone / Fax numbers ____

Professional Relationship to Student ____

Name ____

Address ____

Telephone / Fax numbers ____

Professional Relationship to Student ____

Custodial Parent / Guardian ______________________________ ______________
Signature Date

Custodial Parent / Guardian ______________________________ ______________
Signature Date

Transportation Consent and Release

I hereby grant Explorations, at its sole discretion, to place my child on a public carrier (i.e. airplane, train, bus, and school bus), private or corporate vehicle for the purpose of transporting him/her to such location as communicated by the undersigned to Explorations for all program needs and events.

I hereby release and discharge Explorations, its agents, employees, office and directors from all claims, demands, actions, judgments and executions the undersigned may have against Explorations 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 my child from Explorations as set forth above.

I the undersigned have read the consent and release and understand all of its terms and I execute it voluntarily.

Applicant's Name ____

Custodial Parent/Guardian ______________________________ ______________
Signature Date

Custodial Parent/Guardian ______________________________ ______________
Signature Date

Explorations
Self Discovery through Personal Challenge

Consent to Examination and Treatment

- **We cannot proceed with admissions/enrollment process without complete information and proof of insurance**

Applicant's Name ____ Date _______________

I hereby authorize and consent to any X-ray examination, anesthetic, inoculation, vaccination, medical or surgical diagnosis or treatment and hospital care to be rendered to the above-named minor under general or special supervision and upon the advice of a physician licensed under the provisions of the Medical Practice Act. I hereby consent to X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act.

Custodial Parent/Guardian _______________________________________ _______________
Signature Date

Custodial Parent/Guardian _______________________________________ _______________
Signature Date

Explorations
Self Discovery through Personal Challenge

Medical Insurance

- **Please attach a photocopy of your policy or insurance ID card as proof of insurance.**

Insurance Company ____

Policy Holder ____ Policy No_________________

Policy Holder's D.O.B. ______________________ Policy Holder's S.S.N. ______________________

Employer, If group Policy____

Coverage (Outpatient, Major, Medical, Hospital) ____

Pharmacy Card Number ____

Pharmacy Deductible ____

Explorations
Self Discovery through Personal Challenge

Release of Medical Information

I hereby authorize release of any medical information to Explorations, regarding:

Applicant's Name ____

Custodial Parent/Guardian ____ _______________
Signature Date

Custodial Parent/Guardian ____ _______________
Signature Date

Explorations
Self Discovery through Personal Challenge

Applicant's Medical History

- ***Please Return all medical forms and lab results prior to enrollment***

Applicants Name ____ Date _______________

1. Physician's name and address:

____

____

2. Please list any current or previous health problems affecting student:

____

____

3. Does the student wear glasses or contacts? ☐ Yes ☐ No If yes, please attach prescription.

   Date of last exam: ___________________________

   Eye doctor's name, address and telephone:

   ____

   ____

4. Date of last dental exam: ______________________

   Dentist's name, address and telephone:

   ____

   ____

5. Orthodontist's name, address and telephone: (if under current treatment)

   ____

   ____

6. Has the student ever been hospitalized?

   Reason ____ Date ________________

   Physician ____ Hospital _____________

7. Has the student ever had surgery?

   Reason ____ Date________________

   Physician ____ Hospital_____________

8. Has the student ever experienced a loss consciousness or head trauma?

   Describe circumstances: ____

   ____

   Dates: ____

9. Has the student ever been involved in an accident?

   Injuries: ____

   ____

10. Has the student ever broken a bone? ☐ Yes ☐ No

    If so, which one (s)? ____

    ____

11. Is the student allergic to any of the following?

    ☐ Penicillin ☐ Aspirin ☐ Sulfa

    ☐ Bee or Wasp sting ☐ Hornet or other insects ☐ Shellfish

    ☐ Iodine ☐ Other ______________________________

    ☐ Any other drugs: ____

    If so, what are the reactions? ____

    ____

    Food allergies: ____

    If so, what are the reactions? ____

    ____

12. Does applicant use an inhaler? ☐ Yes ☐ No If yes, please identify and describe: ______________

    ____

    Other allergies/reactions/treatment (hives, hay fever, eczema, asthma, etc.): ____________________

    ____

    ____

13. Has the student experienced any of the following? If so, at what age?

    ☐ Bedwetting ☐ Stuttering ☐ Nail-biting

    ☐ Head-banging ☐ Nightmares ☐ Tics

    ☐ Other ____

14. Please list any fears the student has had (darkness, thunder, death, etc.) and at what age:

    ____

    ____

    ____

    ____

15. Have any of the student's close relatives ever had any of the following diseases? If yes, please indicate which relative:

	Yes	No	Relationship to student
Tuberculosis	☐	☐	______________
Bleeding disorder	☐	☐	______________
Epilepsy or convulsion	☐	☐	______________
Cardiovascular disease	☐	☐	______________
Diabetes	☐	☐	______________
Kidney disease	☐	☐	______________
Cancer	☐	☐	______________
High blood pressure	☐	☐	______________
Muscle disorder	☐	☐	______________
Alcoholism	☐	☐	______________
Drug Addiction	☐	☐	______________
Mental/emotional illness	☐	☐	______________
Any other illness which runs in your family	☐	☐	______________

16. Has the student had any of the following diseases, illnesses, medical problems or disorders? If so please give dates:

☐ __________ Abnormal periods
☐ __________ Abortion
☐ __________ Aids or HIV positive
☐ __________ Anemia (low red blood count)
☐ __________ Anorexia/Bulimia
☐ __________ Arthritis
☐ __________ Bladder or Kidney infection
☐ __________ Bone condition
☐ __________ Chicken Pox
☐ __________ Constipation or Diarrhea
☐ __________ Convulsions or seizures
☐ __________ Dermatitis, eczema
☐ __________ Diabetes
☐ __________ Frequent colds/sore throats
☐ __________ Frequent ear infections
☐ __________ German Measles (3 day)
☐ __________ Hearing disorder
☐ __________ Heart disorder
☐ __________ Hepatitis
☐ __________ High Blood Pressure
☐ __________ Hyperactivity
☐ __________ Liver or Kidney problems

☐ __________ Measles, Red
☐ __________ Mumps
☐ __________ Muscle Weakness
☐ __________ Obesity
☐ __________ Pneumonia, Bronchitis
☐ __________ Polio
☐ __________ Pregnancy
☐ __________ Rheumatic Fever
☐ __________ Scarlet Fever
☐ __________ Scoliosis
☐ __________ Skin infection
☐ __________ Speech Problems
☐ __________ Sexually Transmitted Disease (herpes, gonorrhea, syphilis, etc)
☐ __________ Tuberculosis
☐ __________ Ulcers
☐ __________ Whooping Cough (croup)
☐ __________ Other. Please explain:

____
____
____
____
____

17. Is the applicant currently taking any medications – prescription or over the counter? ☐ Yes ☐ No Please identify the medication, the condition for which prescribed, the prescribing physician, when prescribed, the dosage and frequency taken:

Medication	For what condition	Prescribing Physician	Date initiated Dosage/Frequency

18. Does the applicant have any dietary restrictions? ☐ Yes ☐ No If yes, please identify and describe:

19. Has applicant used medication for behavior problems, depression, mood swings, hyperactivity, etc? ☐ Yes ☐ No If yes please complete the following:

Name of medication | Dosage | Length of time on medication

Did you see a difference before, during or after use of this medication? ☐ Yes ☐ No If yes please describe:

Name of medication | Dosage | Length of time on medication

Did you see a difference before, during or after use of this medication? ☐ Yes ☐ No If yes please describe:

Name of medication | Dosage | Length of time on medication

Did you see a difference before, during or after use of this medication? ☐ Yes ☐ No If yes please describe:

20. Please list any other pertinent medical information not previously listed and any other important information relating to the health history of the student:

____

____

____

____

Vaccine/Test if given as combinations (MMR or MR) enter date in each appropriate box	Date (1st)	Date (2nd)	Date (3rd)	Date (4th)	Date (5th)
Polio (TOPV)					
DPT and/or TD (Diphtheria, Pertussis, Whooping cough and diphtheria only)					
Measles (Rubella-10 day, red measles)					
Rubella (German-3day measles)					
Mumps					
Tuberculosis skin test					
Hepatitis B					
Varicella (Chicken Pox)					

- ***This form represents all known medical history of the student***

Custodial Parent/Guardian ______________________________________ ______________

Signature Date

Custodial Parent/Guardian ______________________________________ ______________

Signature Date

Explorations
Self Discovery through Personal Challenge

Physical Examination

To be completed by a qualified health care provider

- ***Dear health care provider***

  This individual is being considered for a participation in a physically end emotionally challenging outdoor-based program. He/She may, on occasion, hike 5-20 miles per day at elevations of 2,500 to 7,000 feet, and may be involved in outdoor activities such as kayaking, skiing, rock-climbing, and bicycling. We would appreciate your candid appraisal of his/her health. Specify any health reasons (i.e. serious heart or lung defects, bone or joint deformity, etc.) why this person should not be involved in this type of program. Please contact Explorations at 406/827-3863 for further information.

- ***Please make specific entries regarding any abnormal/positive physical findings. Otherwise indicate normal physical findings with a checkmark.***

Students Name ____ Date of last exam ____________

D.O.B. ________________________ Height ____________________ Weight ______________________

Exam Date _______________________ Skin ___________________ Head _________________________

Eyes: Glasses/Contacts ________________________ Vision: R ___________________ L ____________

Ears ____ Whisper hearing test _______________________

Nose/Throat ____

Neck/Lymph ____

Chest ____

Heart ____

Abdomen ____

Genitalia/Hernia ____

Neurological ____

Musculoskeletal ____

Scoliosis ____

Pelvic and/or Breast Exam ____

Significant findings/recommendations ____

____

____

____

____

____

____

____

____

____

____

Physical Examination Continued

Are there any physical impairment which would limit the student's ability to participate in vigorous activities? (i.e. hypoglycemia, history of diabetes, arthritis, chronic knee/back problems, etc.)

____

____

Please list all current medical and/or emotional problems which are now under treatment. Include all medications being taken and the dosage.

____

____

____

Do you recommend patient continue use of above medication(s) ______________________

____

____

Please list any allergies the student has experienced, as well as reactions/medication.

____

____

____

- ***Required laboratory tests (please attach results):***
  1. Tuberculosis Skin Test (date and results)
  2. HIV Test
  3. Tetanus (within past 5 years)
  4. Viral Hepatitis (A, B,& C)
  5. Pregnancy Test

If patience has positive PPD, please indicate day/results of chest x-ray.

- ***General appraisal:***

___________Approval — I find no defects which I consider incompatible with the requirements of Explorations outdoor program.

___________Disapproval — My patient has defects which, in my opinion, clearly constitute unacceptable hazards to his/her health and safety for participation in your program.

- ***All test results must be attached to this examination prior to enrollment in Explorations.***

Please Print

Physician's Name ____

Address ____

City/State/Zip ____

Telephone (____) ____________________Fax (_____) ____________________Date __________

Physician's Signature ____

Explorations Self Discovery through Personal Challenge **Academics**

Wilderness Assessment Course and Summer Wilderness Adventure participants need not complete

Please include copy of Birth Certificate with application

- ***Permission Granted to release School Records***

In order to implement the most appropriate educational plan for the student, transcripts of all previous Junior High School and High School work are required. Please complete the information requested below.

____ ________________

Pupil's Last Name First Middle Date of Birth

This student is applying for enrolment in Explorations programs. Permission is hereby granted for the release of the following school records to:

Explorations
P.O. Box 1469 Trout Creek, Montana 59874
Phone: 406/**827-3863** Fax 406/827-4072

- ***Please provide:***

1. Office Transcripts of Credit
2. Withdrawal grades, including incomplete classes
3. Test data, health records and counseling information
4. Any other records pertaining to the psychiatric or psychological evaluation of the student

Custodial Parent/Guardian ________________________________ ________________
Signature Date

Custodial Parent/Guardian ________________________________ ________________
Signature Date

Please list all Junior High & High Schools or any other educational programs attended (most recent first) with complete addresses:

Name of School	Type of School	Addresses	Grade(s)	Date Attended

- ***Permission to Test***

I hereby give my permission to Explorations to administer tests to my child which are pertinent and appropriate. These may include psychological and/or academic tests.

Custodial Parent/Guardian ________________________________ ________________
Signature Date

Custodial Parent/Guardian ________________________________ ________________
Signature Date

Explorations Notice of Release of Health Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Explorations understands that medical and psychological information about you and your child is personal. We are committed to protecting this information. This Notice of Information Practices applies to all of our records of your Childs care generated and maintained by Explorations.

Understanding Your Health Record Information
Each time your child visits a hospital, physician, or other healthcare provider, the provider makes a record of their visit. Typically, this record contains his/her health history, current symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as "your" medical record, serves as a:

- Basis for planning your child's care and treatment.
- Means of communication among the many health professionals who contribute to your child's care.
- Legal document describing the care your child received.
- Means by which you or a third-party payer can verify that your child actually received the services billed for.
- A tool in medical education.
- A source of information for public health officials charged with improving the health of the regions they serve.
- A tool to assess the appropriateness and quality of care your child received.
- A tool to improve the quality of healthcare and achieve better patient outcomes.

Understanding what is in your child's health records and how his/her health information is used helps you to:

- Ensure its accuracy and completeness
- Understand who, what, where, why, and how others may access your child's health information.
- Make informed decision about authorizing disclosure to others
- Better understand the health information rights detailed below.

Your Rights Under the Federal Privacy Standard
Although your child's health records are the physical property of the healthcare provider who completed it, you have certain rights with regard to the information contained therein. You have the right to:

- Request restriction on uses and disclosures of your child's health information for treatment, payment, and health care operations. Health care operations consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under ' ' 164.502(a)(2)(i) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, like mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. Even in those cases in which you do have the right to request restriction, we do not have to agree to the restriction. If we do, however, we will adhere to it unless you request otherwise or we give you advance notice.
- You may also ask us to communicate with you by alternate means and, if the method of communication is reasonable, we must grant the alternate communication request.

- Receive and keep a copy of this notice of information practices. The law requires us to ask you to acknowledge receipt of your copy.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, if access would cause harm, we can deny or limit access. You do not have a right of access to the following:
  - Psychotherapy notes. Such notes are those that are recorded in any medium by a healthcare provider who is a mental health professional documenting or analyzing a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your child's medical record.
  - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
  - Any of your child's health information that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. ‘ 263a, to the extent that the provision of access to the individual would be prohibited by law.
  - Information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

In other situations, the provider may deny you access but, if it does, the provider must provide you with a review of the decision denying access. These reviewable grounds for denial include:

- When a licensed healthcare professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of psychological and/or emotional, mental well-being of the individual or another person.
- When the PHI (Protected Health Information) makes reference to another person (other than a healthcare provider) and a licensed healthcare provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
- The request is made by the individual's personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review.

If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.

- If you request amendment/correction of your child's health information. We do not have to grant the request if:
  - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If they amend or correct the record, we will put the corrected record in our records.
  - The records are not available to you as discussed immediately above.
  - The record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your child's records (which we may rebut), and how you can complain to our complaint official or to the Department of Health and Human Services. If we grant the request we will make the correction and distribute the correction to those who need it and those you identify to us that you want to receive the corrected information.

You may obtain an accounting of non-routine uses and disclosures those other than for treatment, payment, and health care operations, or of protected health information about them. We do not need to provide an accounting for the following:

- For disclosures to you.
- For disclosures authorized by you.
- For disclosures of limited data sets (partially de-identified data used for research, public health, or health care operations).
- For the facility directory or to persons involved in your child's care or for other notification purposes as provided in ' 164.510 (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for the care of the individual, of the individual's location, general condition, or death).
- For national security or intelligence purposes under ' 164.512(k)(2) (disclosures not requiring consent, authorization, or an opportunity to object).
- Correctional institutions or law enforcement officials under ' 164.512(k)(5) (disclosures not requiring consent, authorization, or an opportunity to object).
- That occurred before April 14, 2003.

If an accounting is requested, we will provide the following within 60 days:

- Date of each disclosure
- Name and address of the organization of person who received the protected health information.
- Brief description of the information disclosed.
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of the written request for disclosure.

The first accounting in any 12 month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

- Revoke your consent or authorization to use or disclose health information except to the extent that we have already taken action in reliance on the consent or authorization.

Our Responsibilities Under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to:

- Maintain the privacy of your child's health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you with this notice as our legal duties and privacy practices with respect to individually identifiable health information we collect and maintain about your child.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU HAVE SUPPLIED US.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

How to Get More Information or to Report a Problem
If you have questions and/or would like additional information, you may contact the Executive Director at 406-827-3863.

Complaints
If you believe your privacy rights have been violated, you may contact or file a complaint with the Executive Director, 119 South Hill Rd. Trout Creek MT 59874

Examples of Disclosures for Treatment, Payment, and Health Operations

Treatment: If you give us consent by signing a release of information or with the regulatory consent granted by the Department of Health and Human Services, we may use or disclose your child's health information for treatment.

Example: A physician, nurse, or other member of your child's healthcare team will record information in your child's record to diagnose your child's condition and determine the best course of treatment for him/her. The primary caregiver will give treatment orders and document what he or she expects other members of the healthcare team to do to treat your child. Those other members will then document the actions they took and their observations. In that way, the primary caregiver will know how you are responding to treatment.

We will also provide your child's physician, other healthcare professionals, or a subsequent healthcare provider with copies of your child's records to assist them in treating your child once we no longer are treating him/her.

Payment: If you give us consent or with the regulatory consent grated by the Department of Health and Human Services we may use or disclose your child's health information for payment.

Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies your child's diagnosis, treatment received, and supplies used.

Health Operations: If you give us consent or with the regulatory consent granted by the Department of Health and Human Services we may use or disclose your child's health information for health operations (see definition above).

Uses and Disclosures Other than for Treatment, Payment, or Health Care Operations

Business Associates: We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your child's health information to the business associate so that they can perform the function(s) we have contracted with them to do and bill you or your third-party payer for services rendered. To protect your child's health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your child's care, your location, and general condition.

Communication with Family: We will communicate with parents or legal guardians only. All other communication will require a release consent unless pre-authorized by a parent or legal guardian.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post marketing surveillance information to enable to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your child's health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information purpose as required by law or in response to a valid subpoena.

Health Oversight Agencies and Public Health Authorities: If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public, they may disclose your child's health information to health oversight agencies and/or public health authorities, such as the department of health.

The Federal Department of Health and Human Services (DHHS): Under the privacy standards, we must disclose your child's health information to DHHS as necessary for them to determine our compliance with those standards.

CONSENT TO USE HEALTH INFORMATION

This form is an agreement between you and Explorations. When we use the word "you" or "your" below, it can mean the parent(s) or the student.

During enrollment at Explorations, we will be collecting what the law calls Protected Healthcare Information (PHI). We need to use this information to decide what treatment is best and to provide treatment. The information we collect may be shared with another agency in a life-threatening emergency situation when we are unable to contact you or another emergency contact or when we are legally bound to do so. As a standard practice, you will be required to sign a release of information authorization prior to most disclosures of your Protected Healthcare Information (PHI).

By signing this form you are agreeing to let us use your information here. The Notice of Privacy Practices explains in more detail your rights and how we can use your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you may get a copy by calling us at 406-827-3863

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment or administrative services. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent , you have the right to evoke it (by writing a letter to our Privacy officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may have already used or shared some of your information and cannot change that.

____ _______________

Signature(s) of client or client's personal representative Date

____ _______________

Printed name(s) of client or personal representative ` Relationship(s) to the client

____ _______________

Signature of authorized representative of Explorations Date

☐ Copy given to the client/parent