FOREST RIDGE
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THE SACRED HEART SCHOOL OF SEATTLE

2019-2020 Residential Life Student Matriculation Packet Checklist

☐ Combined Physical Evaluation and Medical History
☐ School Physical Examination Form
☐ Allergy Questionnaire
☐ Authorization for Administration of Prescription and Over-the-Counter Medication in Residential Life
☐ Authorization for Administration of Medication at School
☐ Custodial Responsibility and Consent for Medical Treatment Authorization
☐ Authorization for Release of Health Information & Consent for Emergency Treatment
☐ Ratification of Matriculation Documents
☐ Transportation Policy
☐ Updated Immunization Form 2019 (additional form)

Residential Life Details	
Dorm Building Phone Number	(425) 641-2155
Dorm Driver Cell Phone	(425) 591-1214
Dorm Campus Cell Phone	(425) 260-2241
Dorm Mailing Address	4750 139th Ave SE, Bellevue, WA 98006

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Combined Physical Evaluation and Medical History

*Student Name: _____
First Name Middle (if any) Last Name English name/Nickname

*School Name: _____ (the "School")

*Please choose 1 or 2 below:

- ☐ **1. Physical evaluation completed on attached English document** *(complete High School and Middle School Physical Examination Form – next page)*
  - The physical evaluation and medical history forms should be provided by a hospital/private doctor. Please provide the most recent report
- ☐ **2. Physical evaluation not complete, will complete in the United States at my own cost.**
  - The School recommends that students complete a physical evaluation before traveling to the United States. If a student has not completed a physical examination before traveling to the United States, they will need an exam completed here before the start of the school term. Please remember, physical evaluations are more expensive in the United States, and schools may not allow a student to attend class if the exam is not complete before the start of class. In addition, students will be responsible for any costs associated with completing the physical exam. The costs of exams can vary from a few hundred dollars to a couple thousand dollars.

Administration Terms of Physical Evaluation

By signing below, I, *_____(Parent/Guardian name), hereby represent that I have the legal authority to agree to the terms of this form for my child and hereby authorize the School or School designated physician to administer my child's physical evaluation in the event that I have chosen to complete it in the United States.

Any and all physical evaluations are subject to the attached Authorization for Release of Information and the Custodial Responsibility Form, both of which are attached hereto and incorporated herein by reference. I acknowledge that I am required to complete both forms.

Medications

*Please list (in English) any medications that your child is currently taking or will be taking during the summer or during the school year.

- ☐ Check here if no medications currently apply

Medication(s)	Dosage(s)	Frequency	Reason for Prescription(s)

I/We hereby affirm that the foregoing is true and correct and the School is authorized to share copies of this Form with the host family or residential services provider, The Cambridge Institute of International Education and its boards, commissions, committees, employees, officers, directors, servants, agents, and assigns.

*Student Signature: _____ Date: _____

*Parent/Guardian Signature: _____ Date: _____

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School Physical Examination Form

*To Be Completed By Participant (Student):

Name: _____ Age: _____ Birthdate: _____ Phone: _____

Address: _____

Medical History: Have you had any of the following:

1. Head injury or concussion	no	yes	12. Hernia (rupture)	no	yes
2. Bone/joint disorder (fracture Broken bones, dislocations, trick Joints, arthritis, back pain)	no	yes	13. Mental illness or nervous breakdown	no	yes
3. Eye or ear problems (disease/surgery)	no	yes	14. "Stinger or burner or pinched nerve"	no	yes
4. Dizzy spells (fainting or convulsions)	no	yes	15. Surgery	no	yes
5. Tuberculosis, asthma or bronchitis	no	yes	16. Taking medication	no	yes
6. Heart trouble	no	yes	17. Allergies or skin problems	no	yes
7. High or low blood pressure	no	yes	18. Heat or muscle cramps	no	yes
8. Anemia, Leukemia or bleeding disorder	no	yes	19. Female: Menstrual problems	no	yes
9. Diabetes, hepatitis or jaundice	no	yes	20. Other illness or injuries	no	yes
10. Ulcers, colitis or other stomach trouble	no	yes	21. Do you use special equipment? (pads, braces, etc.)	no	yes
11. Kidney or bladder problems	no	yes	22. Have you had a medical problem or injury since your last exam?	no	yes

Explain any yes answers:

_____

_____

**To Be Completed By Physician:

Height_____Weight_____Bp_____/____Pulse_____Vision: R 20/_____L 20/_____
Corrected: Yes No Tetanus boosters within last 5 years: Yes No

Cardiopulmonary	Normal	Abnormal	Neck	Normal	Abnormal
Pulses	Normal	Abnormal	Shoulder	Normal	Abnormal
Heart	Normal	Abnormal	Elbow	Normal	Abnormal
Lungs	Normal	Abnormal	Wrist/Hand	Normal	Abnormal
Skin	Normal	Abnormal	Back	Normal	Abnormal
Abdominal	Normal	Abnormal	Knee	Normal	Abnormal
Genitalia	Normal	Abnormal	Ankle/foot	Normal	Abnormal
Musculoskeletal	Normal	Abnormal	Other		

*Clearance (check one): A._____ Cleared B._____ Cleared after completing evaluation/rehabilitation for_____
C._____ Cleared but not for contact sports (Basketball, Soccer, Lacrosse. D._____Not cleared.

Name of Physician_____Date_____

Address_____Phone_____

SIGNATURE OF PHYSICIAN _____

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Allergy Questionnaire

*Student Name: _____
First Name Middle (if any) Last Name English name/Nickname

*School Name: Forest Ridge School of the Sacred Heart (the "School")

Please provide information regarding all known allergies or medical conditions the student currently has. This information helps schools to better evaluate students' needs for arranging their class schedules, as well as determining the right match for residential placements. Such allergies may include, but are not limited to: certain foods, peanuts, other nuts, medication, bee/insect stings, latex, or airborne allergens. Please fill in the following information to the best of your ability.

*Does this student have any known allergies?

- ☐ No (please read and sign on next page)
- ☐ Yes (complete information below in English)

Item	Description (please be specific)
1. Please list: (name of food, peanut, type of nut, medication, bee/insect, latex, or other allergen)	
2. What symptoms does the student usually have, if exposed to allergen?	
3. If the student is exposed to the above allergen during school hours, the following procedure is recommended by the parent and the student's physician:	☐ Watch for symptoms and contact student guardians ☐ Immediately administer medication as indicated on medication form ☐ Call rescue unit (a rescue unit will be called in all situations where a student is experiencing potentially life-threatening symptoms or a prescription epi-pen has been administered.) ☐ Other (please explain):
4. Identify known medical conditions and/or treatments required (attach detailed medical information)	
5. Other Special Instructions (attach an additional sheet, if necessary)	

No prescription drugs or over-the-counter medication of any kind, including herbs or remedies from the student's country may be kept with the student.

All prescription medications are to be turned-in to the host family or residential services provider and will be dispensed according to a doctor's prescription. Host families or residential services provider must be given a local doctor's contact information and be able to communicate directly with the doctor who has prescribed any medication.

School policy requires an Authorization for Administration of Prescription Medication to be completed on all students needing medication at school. Please complete the attached medication form if indicated and send medication to school appropriately labeled. By writing or typing your name below, you indicate consent to these policies.

Any and all physical evaluation is subject to the attached Authorization for Release of Information and the Custodial Responsibility and Consent for Medical Treatment Authorization, both of which are attached hereto and incorporated herein by reference. I acknowledge that I am required to complete both forms.

I/We do hereby affirm that the foregoing is true and correct and authorize the School to share copies of this Form with the host family or residential services provider, commissions, committees, employees, officers, directors, servants, agents, and assigns.

*Parent/Guardian Signature: _____ Date: _____

*Parent/Guardian Signature: _____ Date: _____

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Authorization for Administration of Prescription and Over-the-Counter Medication in Residential Life

*Student Name: _____
First Name Middle (if any) Last Name English name/Nickname

*School Name: Forest Ridge School of the Sacred Heart (the "School")

This authorization and consent for medication is required to be completed and presented to the child's school before any medication may be administered to a child during the school day. It is effective the date it is signed and shall remain effective until the earliest of the following:

a. Termination by operation of law;
b. Revocation of the Custodial Responsibility and Consent for Medical Treatment Authorization by the grantor(s), the custodian(s), or a court of law; or
c. Termination or completion of the student's participation in any program by the School.

Medication Policies

1. I grant permission to the persons designated by the principal to give the following medication(s) to my child according to directions provided with the medication. *Please list medications in English:*

2. I authorize school personnel to exchange information with my child's clinician regarding this medication or the condition for which it is prescribed.
3. I will notify the school in writing of any changes. Prescription medication changes require a new clinician order.
4. Non-prescription dosing may not exceed package recommended dosing without a clinician written order.
5. The medication must be kept in its appropriately labeled, original container, in English.
6. The prescription medication label must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions. Physicians consent for self-administration is to be on the label or medication consent form.
7. Sharing and/or borrowing of the medication with another student are strictly prohibited.
8. It is the parents' and the physician's responsibility to be aware of any possible interactions between parent-supplied prescriptions and over-the-counter medications.

Medication Permissions

1. My child may take medication(s) as above at school, pursuant to a physician's order, without authorized school personnel dispensing the medication(s).

**Please mark your choice*: Yes_____ No_____

2. I understand all medication must be picked up at the end of the school year or it will be destroyed. I give my student permission to transport medication to and from school and will not hold the School or The Cambridge Institute of International Education liable for any accident, injury, or loss of medication that may occur during transport.

**Please mark your choice*: Yes_____ No_____

Any and all physical evaluations are subject to the attached Authorization for Release of Information and Custodial Consent for Medical Treatment Authorization, both of which are attached hereto and incorporated herein by reference. I acknowledge that I am required to complete both forms.

I authorize the School to share copies of this Form with the host family or residential services provider, commissions, committees, employees, officers, directors, servants, agents, and assigns.

*Parent/Guardian Signature_____ Date:_____

*Parent/Guardian Printed Name_____ Date:_____

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Authorization for Administration of Medication at School

Name: _____ Birthdate: _____ Grade (2019-2020 School Year)_____

Please Note: All medication to be administered or taken at school and dormitory must be in original container(s) labeled in English with the student's name, dosage, time, and route (oral, inhaled, topical, injectable…) including over-the-counter (OTC) medications such as cough drops, Advil, Tums, etc.

Medications must accompany this completed form and given to the Registrar, Director of Residential Life, or Summer Program Director.

School staff do not provide OTC medication to day students. Boarding (resident) students are provided OTC medication evenings, weekends and when school not is session by approved residential staff.

Medications must accompany this completed form and given to the Registrar, Dormitory Director, or Summer Program Directors.

<table>
<tr><td colspan="4">Physician or Dentist Must Complete the Following Portion Below</td></tr>
<tr><td>Name of medication(s)</td><td>Dosage(s)</td><td>Time(s) of day to be taken</td><td>Reason for medication</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">If medication administered prn (as needed), specify the length of time between doses:</td></tr>
<tr><td colspan="4">Inhaler(s):</td></tr>
<tr><td colspan="2">Student must carry on her person:</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="2">Student is capable of self-administer inhaler:</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="4">Known side effects of medication(s):</td></tr>
<tr><td colspan="4">Emergency procedure in case of serious side effect:</td></tr>
<tr><td colspan="2">Inhaler expiration date: _____</td><td colspan="2">If epi-pen listed, expiration date of epi pen:
_____</td></tr>
<tr><td colspan="2">I request and authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated from dates: _____to_____, as there exists a valid health reason which makes administration of the medication(s) advisable during school hours or when the dormitory is open.

_____
Physician/Dentist signature</td><td colspan="2">_____
Date

_____
Physician/Dentist Name Printed

_____
Office Phone Number</td></tr>
</table>

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Custodial Responsibility and Consent for Medical Treatment Authorization

I/WE: _____ (Parent/Guardian(s)

Of: _____ (Parent(s)/Guardian(s) Address)

Have full legal and physical custody of: _____ (Name of Child/Minor),

Whose date of birth is: _____ (Child/Minor Date of Birth),

And do hereby appoint individuals listed on the Designation Sheet (those individuals, collectively, the "Custodian") designated by Forest Ridge School of the Sacred Heart (the "School"), (Name of School) to act as Custodian of my child and do the following acts or things in my name and in my behalf:

(1) To take temporary custodianship of my child; and

(2) To act in loco parentis of my child and do all acts necessary for maintaining my child's health, education, and welfare, including the registration and enrollment of my child in educational and recreational programs; to maintain reasonable living standards, including, but not limited to, provision of living quarters, food, clothing, medical, surgical and dental care; entertainment and other customary matters; and

(3) To administer general first aid treatment for my child for injuries or illnesses experienced by my child, and to approve and authorize any and all medical testing and treatment deemed necessary by a certified medical provider and to execute any consent, release or waiver of liability required by medical or dental authorities incident to the provision of medical, surgical or dental care to my child by qualified medical personnel; to consent to surgery or any other medical procedures or assistance to my child; to authorize my child's admission to a medical, nursing or residential care facility and to enter into agreements for my child's care.

Emergencies and Situations of Significant Risk

(1) In emergency situations, the Custodian shall attempt to contact the Parent/Guardian before making health care decisions, including the consent for emergency transportation if necessary.

(2) If treatment decisions carry significant risks to my child, in the judgment of the Custodian, and time permits contact with me before treatment is undertaken, the Custodian or the School will make reasonable efforts to contact me for approval utilizing the contact information set forth below. In the event that I cannot be reached within a reasonable time, and the Custodian, on the advice of a licensed physician, surgeon or dentist, determines that the treatment decision should be made without further delay, the Custodian may approve such treatment.

Parent/Guardian # 1

Given Name	**Middle (if any)**	**Last Name**	**English name/Nickname**
Email Address:			
Mobile Phone:			
Postal Address:			

Parent/Guardian # 2

Given Name	Middle (if any)	Last Name	English name/Nickname
Email Address:			
Mobile Phone:			
Postal Address:			

Effective Date and Termination

This Custodial Responsibility and Consent for Medical Treatment Authorization ('Authorization") shall become effective 12:01 AM on the _____ (day) of _____(month) _____ (year) and shall remain effective until the earliest of the following:

a. Termination by operation of law;
b. Revocation of this Custodial Responsibility and Consent for Medical Treatment Authorization by the grantor(s), the custodian(s), or a court of law; or
c. Termination or completion of the Student's participation in all programs by the School and the Cambridge Institute of International Education.

Parent/Guardian Approval of Custodian's and the School's Actions; Indemnity

I do hereby ratify and confirm the School's selection of the Custodian and each of the acts of the Custodian lawfully done, on my behalf, pursuant to the authority herein above conferred.

I am aware that the exercise of the powers and authority granted herein may involve expenses to my child and/or me. I approve the reasonable expenses associated with the activity, provided that those expenses do not exceed the amounts being charged to other students for the same activity or event. Any activity or event for which the charge would exceed $250 will not be approved by the Custodian for my child without advance consent from me, unless I cannot be reached through reasonable means. The Custodian shall not be responsible for damages or losses incurred by my child or me caused by my failure to respond within a reasonable time to a request for approval of participation in activities or trips.

I agree, to the fullest extent permitted by law, to indemnify, hold harmless, and defend the School, and any of their affiliates, subsidiaries, boards, commissions, committees, employees, officers, directors,
servants, agents, contractors, and assigns, whether past, present, or future (collectively, "Indemnified Parties"), from any and all claims, demands, actions, liabilities, losses, damages, settlements, judgments, costs, and expenses (including reasonable attorneys' fees), which are related to or may arise directly or indirectly out of the Indemnified Parties' performance under, use of or reliance upon this Authorization, but excluding claims arising from the gross negligence of the Indemnified Parties. This provision will survive termination or expiration of this Authorization.

Health and Accident Insurance

I agree to maintain medical and accident insurance for my child. I further agree to reimburse the Custodian any and all charges approved by the School for any treatment not covered by medical insurance. The school's insurance is preferred and offered to each student.

Other Provisions

This Authorization is written in the English language. In case of discrepancies between the English text version of this Authorization and any translation, the English version shall prevail.

All pronouns and any variation thereof refer to the masculine, feminine or neuter, singular or plural, as the identity of the person or persons may require.

Photocopies of this Authorization shall have the same force and effect as the original.

This Authorization is intended by me to be valid in any jurisdiction in which it is presented. The various powers granted herein are separate and severable to the effect that the possible invalidity of any one or more of such powers shall not affect the validity of any other powers.

I authorize the Custodian and the School to share copies of this Authorization with the host family or residential services provider, and its boards commissions, committees, employees, officers, directors, servants, agents, and assigns.

The validity and interpretation of this Authorization shall be governed by the laws of the State where the School is located, without regard to its choice of law provisions or the choice of law provisions of other jurisdictions.

It is understood that this Authorization is given in advance of custody of my child and any such medical treatment and is given to provide authority and power on the part of the Custodian in the exercise of his or her best judgment.

Date: _____ _____

Signature of Parent/Guardian

Date: _____ _____

Signature of Parent/Guardian

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Statement Of Witnesses

I declare under penalty of perjury:

(1) That the individual who signed or acknowledged this Custodial Responsibility and Consent for Medical Treatment Authorization is personally known to me, or that the individual's identity was proven to me by convincing evidence,

(2) That the individual signed or acknowledged this Custodial Responsibility and Consent for Medical Treatment Authorization in my presence,

(3) That the individual appears to be of sound mind and under no duress, fraud, or undue influence,

(4) That I am not a person appointed as agent by this Custodial Responsibility and Consent for Medical Treatment Authorization, and

(5) That I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness

Printed Name:	
Signature:	
Date:	
Postal Address:	

Second Witness

Printed Name:	
Signature:	
Date:	
Postal Address:	

ONE OF THE PRECEDING WITNESSES ALSO MUST SIGN THE FOLLOWING DECLARATION:

I further declare under penalty of perjury that I am not related to the individual executing this Custodial Responsibility and Consent for Medical Treatment Authorization by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: _____ Signature: _____

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Authorization for Release of Health Information & Consent for Emergency Treatment

School Name: Forest Ridge School of the Sacred Heart (Name of School)

I, _____ (Name of Student),

Of _____ (Address)

hereby authorize The School, and their respective designees listed on the Designation Sheet (collectively referred to as the "Authorized Agent") to receive from any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to the Authorized Agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical condition.

In addition to the above release, by marking the line below, I specifically authorize the release of:

____ Information pertaining to drug and alcohol abuse, diagnosis and treatment;

____ Mental health information, excluding psychotherapy notes.

____ HIV/AIDS test results;

____ Genetic Testing information;

I authorize the Authorized Agent to disclose any and all medical information to the School at which I am enrolled on my behalf.

The authority given to the Authorized Agent shall supersede any prior agreement that I may have made with the with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given to the Authorized Agent will not expire unless I revoke the authority in writing and deliver it to the minor's health-care provider or until the earliest of the following:

a. Revocation of this Authorization by a court of law; or

b. Termination or completion of my participation in all programs by the School.

CONSENT FOR EMERGENCY TREATMENT

In emergency situations where I am unconscious or otherwise unable to make health care decisions for myself, and in order to preserve my life, limbs or wellbeing, the Authorized Agent shall attempt to contact my one of the two individual's listed below before making health care decisions, including the consent for emergency transportation if necessary.

If time permits contact with one of my family members before treatment is undertaken, the Authorized Agent will make reasonable efforts to contact them for approval utilizing the contact information set forth below. In the event that my family member cannot be reached within a reasonable time, and on the advice of a licensed physician, surgeon or dentist, determines that the treatment decision should be made without further delay, the individuals listed on the Designation Sheet may approve such treatment.

Contact Information # 1

Given Name	**Middle (if any)**	**Last Name**	**English name/Nickname**
Email Address:			
Mobile Phone:			
Postal Address:			

Contact Information # 2

Given Name	Middle (if any)	Last Name	English name/Nickname
Email Address:			
Mobile Phone:			
Postal Address:			

OTHER PROVISIONS

(1) Photocopies of this Authorization shall have the same force and effect as the original.

(2) This Authorization was written in English. Any translations of this Authorization are provided for convenience only and shall have no legal effect on the interpretation or enforceability of this Authorization.

(3) This Authorization is intended by me to be valid in any jurisdiction in which it is presented. The various powers granted herein are separate and severable to the effect that the possible invalidity of any one or more of such powers shall not affect the validity of any other powers.

INDEMNIFICATION

I agree, to the fullest extent permitted by law, to indemnify, hold harmless, and defend the School, and any of their affiliates, subsidiaries, boards, commissions, committees, employees, officers, directors, servants, agents, contractors, and assigns, whether past, present, or future (collectively, "Indemnified Parties"), from and against any and all claims, demands, actions, liabilities, losses, damages, settlements, judgments, costs, and expenses (including reasonable attorneys' fees), which are related to or may arise directly or indirectly out of the Indemnified Parties' use or reliance upon this Authorization, but excluding claims arising from the gross negligence of the Indemnified Parties. This provision will survive termination or expiration of this Authorization.

I UNDERSTAND THAT THIS AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION AND CONSENT FOR EMERGENCY TREATMENT IS VOLUNTARY. I ALSO UNDERSTAND THAT THE PERSON OR ORGANIZATION I AUTHORIZE TO RECEIVE THE INFORMATION IS NOT SUBJECT TO FEDERAL HEALTH INFORMATION PRIVACY LAWS, THEY MAY FURTHER RELEASE THE PROTECTED HEALTH INFORMATION AND IT MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY LAWS.

*Parent Signature: _____ Date: _____

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Ratification of Matriculation Documents

School Name: Forest Ridge School of the Sacred Heart (Name of School)

I, _____, (Name of Student) hereby declare as follows:

I entered into, or my parent(s)/legal guardian(s) entered into, the following contracts, agreements, and releases ("Matriculation Documents") with the School, in order to facilitate my studying abroad and attending secondary school in the United States:

(1) Authorization for Administration of Prescription Medication;
(2) Allergy Questionnaire;
(3) Combined Physical Evaluation and Medication History; and
(4) International Student Enrollment Contract.

My birthdate is _____ [date]. On the date of execution of the above-described, I was _____ years of age and a minor under the laws of the State of the School's location. I am now years of age and have attained majority under the laws of the State of the School's location.

I have reviewed the above Matriculation Documents and a copy of this Ratification is attached to each Matriculation Document in the file at the offices of the School.

I understand that under the laws of the State of the School's location, I have the right to disaffirm the above-described Matriculation Documents.

In consideration of my continued participation in the programs offered by the School, I hereby ratify and confirm each of the above-described documents and my obligations thereunder, and waive my right to disaffirm all or any part of them on the basis of minority at the time of their execution. In all cases where the defined term "Parent" is used in any such document, my name shall be added to and included within such definition for all purposes thereunder.

Executed at _____ [city], _____[state], on _____ [date]

*Student Signature: _____

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Designation Sheet

The School, pursuant to the requirements enumerated in the Authorization for Release of Information, the Custodial Responsibility and Consent for Medical Treatment Authorization, and the Authorization for Release of Health Information & Consent for Emergency Treatment, hereby designate the following individuals, in the order they are listed below, to act on behalf of or consent for _____(name of student) while the Student is participating in the Program:

1) _____, the Main Residential Life Contact Position),
2) _____. Director of English Immersion Summer Program and/or, Assistant Director or Director of Residential Life or Principal during academic year, (the main school contact position)
3) _____, Head of School.

Once this Designation Sheet has been completed by the School it shall be attached to all documents that reference a Designation Sheet and a copy shall be provided to the host family or residential provider. Furthermore, The School and The Cambridge Institute of International Education, Inc. reserve the right to modify, change, or exchange the individuals listed on this sheet at any time.

IN WITNESS THEREOF, The School and its designated the above individuals.

_____

Forest Ridge School of the Sacred Heart
Head of School

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Transportation Policy

The Director of Residential Life is responsible for coordinating all student transportation and students are asked to make social transportation requests with at least forty-eight (48) hours' notice, however more time is always preferable.
Forest Ridge guarantees transportation to the following:

- Dorm organized activities
- School commitments (such as club competitions, community service, etc.)
- SAT/ACT/TOEFL (at approved test centers in Bellevue, Kirkland, Renton and Seattle only and minimum 4 week notice)
- Medical appointments

Outside of these situations, all dorm students have the following transportation options available to them:

1) On weekends (Friday 3:30pm-Sunday 5pm) and non-school days students may use local taxi companies for personal transportation outside of regularly scheduled dorm activities and trips at their own expense. Students may use taxis under the following conditions:
    - Their parents have signed the appropriate passenger permission forms
    - They have communicated their plans to the Director of Residential Life with 24 hours' notice
    - They travel in groups of two (2) or more
    - They follow proper sign out and sign in procedure

Residential Life students over the age of 18 years old may have privileges to use Uber/Lyft app if the following criteria are met:

1) Their parents have signed the appropriate passenger permission form
2) They have verbally communicated their plans to the Residential Life staff prior to requesting a ride
3) They travel in groups of two (2) or more (all riders must be over 18 years old)
4) Use Uber/Lyft at their own expense
5) They follow proper sign out and sign in procedure
6) Are in good academic and dorm standing

Students are responsible for the cost of any trip taken by taxi/Uber/Lyft and should be prepared to pay the driver.

Note: Students under 18 years old may not use rideshare services without a parent/guardian present (Uber, Lyft, etc. as these services do not allow them to transport minors without parents/guardians.

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2019-2020 Residential Life Transportation Permission Form

*Student Name: _____
First Name Middle (if any) Last Name English name/Nickname

Terms of Transportation

In order to assure the safety of our students, anyone driving students for school-sponsored events must be designated as an authorized driver. Parent/guardian(s) must indicate preferences from the choices below:

Passenger Permission

As a parent/guardian, I give permission for my child to travel with the indicated transportation preferences for any school-sponsored events, including, but not limited to, field trips and athletic events. In addition to school-sponsored events, residential students may be invited off campus with day students and/or their families for weekend or after school social activities.

Check all that apply:

____ My child has permission to ride with an authorized Forest Ridge adult over the age of 25 years old.

____ My child has permission to ride with an authorized Forest Ridge driver who is under 25 years old and is legally permitted to transport minors under 20 years old in the state of Washington.

Taxi Permissions

Forest Ridge residential students are permitted to use taxis at their own expense for personal off campus transportation when traveling in groups of two (2) or more and remain in good standing in the dorm.

Parent/guardian(s) must indicate preferences from the choices below.

___ I give my permission for my child to travel off campus in a taxi.

___ I do **not** give my permission for my child to travel off campus in a taxi.

Residential Student Privileges Over 18 years old as of First Day of School Year (2019-2020) and after

Parent/guardian(s) must indicate preferences from the choices below.

___ I give my permission for my child to travel off campus using the Uber/Lyft app.

*Parent Signature: _____ Date: _____

*Student Signature: _____ Date: _____