

# Application & Enrollment Information



## Once accepted, these forms must be completed:

1. Contact Information Form (1 Page)
2. Participation Agreement (1 page)
3. Cell Phone / Food / Student Account Form (1 Page)
4. Tuition & Fee Schedule
5. Mandatory Health Forms
6. Group RX Registration Forms (All students required to enroll)

## For *International Students* Only:

1. Arrival Flight Information (1 page)
2. Guardian Information Form (1 page)

**Please contact the Admission Office, at (440) 275-2811  
or at [admissions@grandriver.org](mailto:admissions@grandriver.org)**

We look forward to seeing your son very soon!

# Grand River Academy

## Contact Information Form

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Send Tuition & Expense Billings to:

Edline Information Should be Sent To:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Others that Academy publications (newsletters and notices) should be sent:

\_\_\_\_\_

**Important Contact Information:**

**Father:**

**Mother:**

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Cell #: \_\_\_\_\_

Cell #: \_\_\_\_\_

**In case of emergency and the parents can not be reached, please call:**

\_\_\_\_\_  
*Name Relationship Home Phone Cell Phone*

\_\_\_\_\_  
*Name Relationship Home Phone Cell Phone*

**Grandparents Addresses and emails:**

\_\_\_\_\_  
*Name & Address Email*

\_\_\_\_\_  
*Name & Address Email*

**Your hometown newspaper or the paper that you read most frequently:**

\_\_\_\_\_  
*Name of Paper & Address*

\_\_\_\_\_  
*Name of Paper & Address*

# Grand River Academy

## Permission to Participate / Hold Harmless Agreement

I grant permission for my son to participate in the following activities that are offered/sponsored by the Academy. Parents may be contacted if the cost is above the routine activity fee and/or it involves extensive travel. Restrictions to selected activities may be imposed by the Academy based on monthly grade reports.

- Paintball
- Interscholastic Sports
- Amusement Parks
- Water Parks / Swimming
- Skiing / Snowboarding (season pass will be available for purchase)
- Concerts (usually around \$40 - \$60)
- Weight Lifting
- Bicycling
- Bowling
- Hiking
- Overnight Camping
- Regularly Scheduled Weekend Activities (movies, mall, sporting events, etc...)

The parent(s) / guardian(s) hereby release Grand River Academy, its agents, servants or employees, from any liability for damage of any kind or nature whatsoever (including death resulting there from) to the student from the student's participation in the above activity unless such damage or injury results from the negligence or willful misconduct of Grand River Academy. In the event that a student shall make a claim against a student, the Guardian(s) shall defend and hold harmless Grand River Academy from any damages or other liabilities, costs, and expenses of whatever nature resulting there from (including attorney fees) which may be sustained by Grand River Academy as a result of such claim.

\_\_\_\_\_ Parent(s) or Legal Guardian(s)

\_\_\_\_\_ Student \_\_\_\_\_ Date

# Cell Phone Registration

**Student Name:** \_\_\_\_\_

**Cell Phone Model:** \_\_\_\_\_ **Serial #:** \_\_\_\_\_

**Cell Phone Number:** \_\_\_\_\_

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# Food Service Information

**Student Name:** \_\_\_\_\_

**Food Allergies, vegetarian, religious requirements, likes, dislikes:**  
\_\_\_\_\_  
\_\_\_\_\_

**My Favorite Food/Dish:**  
\_\_\_\_\_

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# Student Center Account

We recommend \$20 to \$35 a week for snack items purchased in the Student Center. Please fill in the information below. There is no cash allowance account or cash withdrawals permitted from the student expense account. Parents can change the weekly limit at any time with a phone call / email to the business office.

**Student Name:** \_\_\_\_\_

**Weekly Limit:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_

## Tuition & Fee Schedule 2016 - 2017

|  | <u>7-day Boarding</u> | <u>5-day Boarding</u> |
|--|-----------------------|-----------------------|
| <b>Tuition</b>                             | \$44,460              | \$42,745              |
| 1 <sup>st</sup> Payment (with Contract)    | \$13,000              | \$12,500              |
| 2 <sup>nd</sup> Payment (August 1, 2016)   | \$12,000              | \$10,750              |
| 3 <sup>rd</sup> Payment (October 1, 2016)  | \$12,000              | \$10,750              |
| 4 <sup>th</sup> Payment (January 15, 2017) | \$ 7,460              | \$ 8,745              |

Note: Tuition includes all student expenses except: Laundry, Student Center Purchases, Transportation, Counseling, weekend activities, The *FOUNDATIONS* Learning Program, medical payments and textbooks.

**Day Student Tuition** \$15,600  
Ashtabula County Day Student Scholarship \$5,000

**GRA Summer Academy** \$6,000 (7-day) \$6,500 (International)  
The Summer Academic Camp is an all-inclusive tuition. The only expense not included is Student Center purchases, medical co-pays, and personal spending money.

### **Other Fees:**

Student Expense Account Deposit (Laundry, Weekend Activities, Student Center Purchases, Transportation, etc)

7-day Boarder: \$500      5-day Boarder: \$400      International: \$2,000

### **Supplemental Programs:**

The *FOUNDATIONS* Learning Program: \$4,500 per semester  
Individualized and personalized support for students with learning differences such as ADD, ADHD, dyslexia, and other reading difficulties.

International Student Fee: \$8,000

The international student fee includes the services of the international student advisor, administrative costs, ESL services, test prep services and an expanded university placement program.

International Student Health Insurance: \$1,400 was the 2015-16 rate

This is mandatory for all international students and is included in the student expense account fee.

### **Tuition Lock Program (Returning Students Only)**

Option 1: With a \$5,000 non-refundable deposit by April 1<sup>st</sup>, the previous years' tuition rate will be locked in.

Option 2: Pay in full by July 1, 2016, the previous years' tuition rate will be locked in.



## *Mandatory Health Forms*

All these forms must be completed prior to enrollment

### **Contact Information:**

School Nurse: [nurse@grandriver.org](mailto:nurse@grandriver.org)

Admissions: [admissions@grandriver.org](mailto:admissions@grandriver.org)

### **Checklist of Required Forms & Items:**

1. **Emergency Treatment Form** (1Page)
2. **Physical Evaluation & Vaccination Forms** (1 Pages)
  - a. This form must be signed by the Physician
3. **Request for the Administration of Non-Prescription Medication Form** (1 Page)
  - a. This form must be signed by a parent or guardian and a physician. "Yes" column must be marked to administer medications.
4. **Request for the Administration of Prescription and Specific Non-Prescription Form** (1 Page)
  - a. This form must be signed by a parent or guardian and a physician.
5. Photocopy of both sides of the **Insurance Card**
6. **Group RX Agreement Form**
  - a. Sign the Agreement Form
  - b. Register online

Please make sure all forms are completely filled out and signed when needed.

These forms can also be found on our website at [www.grandriver.org](http://www.grandriver.org)

# Emergency/Routine Care Medical Authorization

## Grand River Academy

3042 College St., PO Box 222

Austinburg, OH 44010

Phone: 440-275-2811 Fax: 440-275-1825

STUDENT Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home phone \_\_\_\_\_ Cell (Mother) \_\_\_\_\_

Cell (Father) \_\_\_\_\_

Father's SSN \_\_\_\_\_ Father's Date of Birth \_\_\_\_\_

Mother's SSN \_\_\_\_\_ Mother's Date of Birth \_\_\_\_\_

3<sup>rd</sup> Party Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell \_\_\_\_\_

### **ALLERGIES TO MEDICATIONS-- If no allergies, write NONE**

### **\* INSURANCE CARDS, PLEASE PROVIDE PHOTOCOPIES FRONT and BACK**

#### **Consent Statement: Authorizing Treatment**

In the event that Academy personnel have been unable to contact me concerning a medical emergency, I hereby give my consent for the administration of treatment deemed necessary by Academy personnel, local physician and/or hospital. Question may arise as to whether or not there may be objection to the use of certain forms of treatment, such as antibiotics, blood transfusions.

To eliminate the possibility of misunderstanding, please indicate below your wishes in case of emergency.

I give my consent for discharge from treatment to Academy personnel following completion of such treatment.

My signature is considered binding for the duration of my child's attendance at the Academy unless otherwise notified in writing.

Forms of treatment to which you object: If none, write none.

Custodial Parent/Guardian Signature: \_\_\_\_\_

Student's Signature (if over 18): \_\_\_\_\_

## Physical Evaluation: Grand River Academy

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

**To be completed by the physician:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_

|                               | Normal | Abnormal | Comment |
|-------------------------------|--------|----------|---------|
| Head, Eyes (PERL), Ears, Nose |        |          |         |
| Mouth, Teeth, Pharynx         |        |          |         |
| Neck, Thyroid, Lymph Nodes    |        |          |         |
| Lung sounds                   |        |          |         |
| Heart_rhythm/rate             |        |          |         |
| Abdomen                       |        |          |         |
| Extremities, joints           |        |          |         |
| Spine                         |        |          |         |
| Skin                          |        |          |         |

Do you have any allergies? (medicine, insects, environmental) \_\_\_\_\_

Any other medical concerns school should be aware of? \_\_\_\_\_

**Cleared for Sports:**

|                                       | YES | NO |
|---------------------------------------|-----|----|
| Cleared without restrictions          |     |    |
| Not cleared for Sports                |     |    |
| If not cleared, please explain: _____ |     |    |

**To be completed by the physician:**

Immunizations (Ohio Law--- Shaded areas are required by law)

|                                       | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 |
|---------------------------------------|--------|--------|--------|--------|--------|
| DPT diphtheria, pertusis, tetanus     |        |        |        |        |        |
| Tdap Booster, 7 <sup>th</sup> grade   |        |        |        |        |        |
| Polio                                 |        |        |        |        |        |
| Measles, Mumps, Rubella               |        |        |        |        |        |
| Hepatitis B                           |        |        |        |        |        |
| Varicella (chicken pox)               |        |        |        |        |        |
| BCG ( <i>international students</i> ) |        |        |        |        |        |
| Meningitis                            |        |        |        |        |        |

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

Name of Physician (Print) \_\_\_\_\_ Phone \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_



## Administration of Prescription & Non-prescription Medication by School Personnel

Ohio law mandates that schools have on file a signed statement by the parent/guardian and physician for all medications administered to students. Prescription and non-prescription (over-the-counter) medications will be held by the Health Center or residential staff in the dormitories and administered according to direction by the school nurse and/or member of the Grand River Academy staff. Students **are not** permitted to have any prescription or over-the-counter medication in their possession with the exception of Epi-pen, inhalers, and insulin supplies.

**This form is required to be signed by a physician every time there is a change and/or addition to prescription and Non-prescription medications.**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies to Meds \_\_\_\_\_ (if no allergies, write NONE).

I request that the above named student be given the medication(s) listed below which is being supplied through Group Rx

| Name of <b>Prescription</b> Med. | Dosage | Time Given | Purpose |
|----------------------------------|--------|------------|---------|
|                                  |        |            |         |
|                                  |        |            |         |
|                                  |        |            |         |

Example of **Non-prescription** medications include, but not to be limited to: Fish/Krill oil, **ANY vitamins**, melatonin, acid-reducers (pepcid), anti-histamines (Claritin, Zyrtec), nutritional supplements, etc...

| Name of Non-Pres. Med. | Dosage | Time Given | Purpose |
|------------------------|--------|------------|---------|
|                        |        |            |         |
|                        |        |            |         |
|                        |        |            |         |

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name of Physician (Print) \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Fax \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**FOR PHYSICIAN ONLY: Discontinue the following**

Medication \_\_\_\_\_

Physician Signature: \_\_\_\_\_

# REQUEST FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies to Meds: \_\_\_\_\_ (if no allergies write NONE).

Ohio law mandates that schools have on file a signed statement by the parent/guardian **and physician** for all non-prescription (over-the-counter) medications that are administered to students.

Students are not permitted to have any non-prescription medication in their possession.

Non-prescription medications listed below are available at the school. Please mark 'YES' or 'NO' for each medication listed to dispense as deemed necessary for minor illness/injury at the discretion of the School Nurse and/or school personnel.

| YES | NO | Medication                                                                                   |
|-----|----|----------------------------------------------------------------------------------------------|
|     |    | Tylenol (acetaminophen)      relieve pain, reduce fever/discomfort                           |
|     |    | Advil, Aleve, Motrin(Ibuprofen)      relieve pain, reduce swelling                           |
|     |    | DayQuil      relieve cold/nasal symptoms                                                     |
|     |    | Pseudoephedrine HCL      nasal decongestant                                                  |
|     |    | Mucinex regular      loosen mucus, clear congestion                                          |
|     |    | Delsym      cough suppressant                                                                |
|     |    | Antihistamine (Zyrtec, Claritin, Chlor-Tab)      seasonal allergies, mild allergic reactions |
|     |    | Guaifenesin      help with congestion                                                        |
|     |    | Antacid tablets/Pepto Bismol/Pepcid AC      relieve indigestion                              |
|     |    | Topical Antibiotic      prevent infection/minor skin scrapes                                 |
|     |    | Hydrocortisone cream      itching/minor skin irritations                                     |
|     |    | Throat lozenges      sore throat/cough                                                       |
|     |    | Visine/eye wash      relieve eye irritations                                                 |
|     |    | Sting swab      relieve pain from insect bite/sting                                          |
|     |    | Deep Woods OFF      protects against mosquitoes, ticks, other insects                        |
|     |    | Anti-diarrheal      relieve symptoms of diarrhea                                             |
|     |    | Laxative      relieve symptoms of constipation                                               |
|     |    | Muscle rub      sore muscles/joint pain                                                      |
|     |    | Sun screen      protect against sun burn                                                     |
|     |    | Sun tan/burn relief      aloe & lidocaine for sun burn                                       |
|     |    | Canker melts      relieve symptoms of canker sore                                            |
|     |    | Calagel      minor skin irritations/itching                                                  |
|     |    | Oragel      relieve symptoms of canker sores, tooth pain                                     |

Students are not permitted to have any medications on their person with the exception of epi-pens, inhalers, and insulin. By signing below I grant permission for the administering of the medications listed above as deemed necessary by the School Nurse and Grand River Academy personnel.

**SIGNATURE of PHYSICIAN** \_\_\_\_\_ Date \_\_\_\_\_

**SIGNATURE of PARENT/GUARDIAN** \_\_\_\_\_ Date \_\_\_\_\_

## Administration of Prescription & Non-prescription Medication by School Personnel

Ohio law mandates that schools have on file a signed statement by the parent/guardian and physician for all medications administered to students. Prescription and non-prescription (over-the-counter) medications will be held by the Health Center or residential staff in the dormitories and administered according to direction by the school nurse and/or member of the Grand River Academy staff. Students **are not** permitted to have any prescription or over-the-counter medication in their possession with the exception of Epi-pen, inhalers, and insulin supplies.

**This form is required to be signed by a physician every time there is a change and/or addition to prescription and Non-prescription medications.**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies to Meds \_\_\_\_\_ (if no allergies, write NONE).

I request that the above named student be given the medication(s) listed below which is being supplied through Group Rx

| Name of <b>Prescription</b> Med. | Dosage | Time Given | Purpose |
|----------------------------------|--------|------------|---------|
|                                  |        |            |         |
|                                  |        |            |         |
|                                  |        |            |         |

Example of **Non-prescription** medications include, but not to be limited to: Fish/Krill oil, **ANY vitamins**, melatonin, acid-reducers (pepcid), anti-histamines (Claritin, Zyrtec), nutritional supplements, etc...

| Name of Non-Pres. Med. | Dosage | Time Given | Purpose |
|------------------------|--------|------------|---------|
|                        |        |            |         |
|                        |        |            |         |
|                        |        |            |         |

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name of Physician (Print) \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Fax \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**FOR PHYSICIAN ONLY: Discontinue the following**

Medication \_\_\_\_\_  
Physician Signature: \_\_\_\_\_

## Administration of Prescription & Non-prescription Medication by School Personnel

Ohio law mandates that schools have on file a signed statement by the parent/guardian and physician for all medications administered to students. Prescription and non-prescription (over-the-counter) medications will be held by the Health Center or residential staff in the dormitories and administered according to direction by the school nurse and/or member of the Grand River Academy staff. Students **are not** permitted to have any prescription or over-the-counter medication in their possession with the exception of Epi-pen, inhalers, and insulin supplies.

**This form is required to be signed by a physician every time there is a change and/or addition to prescription and Non-prescription medications.**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies to Meds \_\_\_\_\_ (if no allergies, write NONE).

I request that the above named student be given the medication(s) listed below which is being supplied through Group Rx

| Name of <b>Prescription</b> Med. | Dosage | Time Given | Purpose |
|----------------------------------|--------|------------|---------|
|                                  |        |            |         |
|                                  |        |            |         |
|                                  |        |            |         |

Example of **Non-prescription** medications include, but not to be limited to: Fish/Krill oil, **ANY vitamins**, melatonin, acid-reducers (pepcid), anti-histamines (Claritin, Zyrtec), nutritional supplements, etc...

| Name of Non-Pres. Med. | Dosage | Time Given | Purpose |
|------------------------|--------|------------|---------|
|                        |        |            |         |
|                        |        |            |         |
|                        |        |            |         |

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name of Physician (Print) \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Fax \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**FOR PHYSICIAN ONLY: Discontinue the following**

Medication \_\_\_\_\_  
Physician Signature: \_\_\_\_\_

**Grand River Academy**  
**HIPAA Waiver Authorization**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA), a federal privacy law, protects individual identifiable health information. HIPAA requires an authorization in order for Grand River Academy to be able to use or disclose protected health information (PHI). This authorization describes the scope and nature.

I authorize Grand River Academy to use and disclose protected health information for the purposes described below:

*\*Medical history, results of physical exams, blood tests, X-rays, and other diagnostic and medical procedures*

*\*To allow Grand River Academy to speak to medical personnel for reasons that may include doctor's visits, hospital visits, and medical emergencies*

Grand River Academy complies with HIPAA and its privacy requirements and all other laws that protect privacy. We will protect information according to these laws. Despite these protections, there is a possibility that information could be used or disclosed by someone else to whom it is released in a way that it will no longer be protected.

I authorize the use of identifiable health information as described in this form.

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Student Name for which this waiver is applicable (Please Print)

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Name of Parent or Representative (Please Print)

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Signature of Parent or Representative

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Signature of Student (if over 18 years of age)

## STUDENT MEDICATION GUIDELINES FOR PARENTS/GUARDIANS GROUP RX

### (Please remember to register online also)

Group Rx is the contracted pharmacy of the Grand River Academy. They provide us with all of our medications and over-the-counter items, which includes vitamins, minerals, and/or supplements. All parents/guardians are required to register their student with GroupRx whether or not they are currently on any medications. You can register online at <https://grouprx.net/registration/school/> or you can download the registration packet and either email, fax, or mail it to GroupRx. Once you register your student with GroupRx, they will provide any medications/over-the-counter items that your student needs, bill your insurance company using the insurance information you provide, and then bill you for any medication/over-the-counter items not covered by your insurance as well as any fees described below.

GroupRx accepts over multiple insurance plans. Your insurance company determines your co-payment with GroupRx. Please let them know if you have a particular state Medicaid and/or a 90-day mail order plan. If you have any questions regarding your insurance please call GroupRx at (201)258-3953 and ask for Joshua Sarnowski at Ext. 1008 or Director Jonathan Williams at Ext. 1006 and he will help you with these issues or refer you to Grand River for further advice.

All medications/over-the-counter items dispensed to your student by our health center require physician orders. **THIS FORM IS IN ADDITION TO THE PRESCRIPTION GIVEN TO GROUP RX.** A copy of the Medication Administration Authorization form is attached and must be signed by a physician for all medications and over-the-counter items you authorize your student to receive while he/she is enrolled at Grand River.

Once an original prescription is received by GroupRx, they will FedEx the medicine pre-packaged in individual dose packets. This method of dispensing medication will minimize potential medication errors insuring that every student gets the correct medication and dosage at the correct time every day. If a medication is added, discontinued, or a dosage changed, you must notify GroupRx and our health center in writing before the change in medication can be completed.

**GroupRx has provided a checklist of helpful things to help expedite medication delivery.**

**I have read and understand the above information (please sign below):**

\_\_\_\_\_ (Parent/Guardian)

Student Name \_\_\_\_\_ Date \_\_\_\_\_

**You can register online at [www.grouprx.net](http://www.grouprx.net)**



The next two (2) forms are for:  
*International Students*

**Contact Information for International Students:**

Admissions Questions: [admissions@grandriver.org](mailto:admissions@grandriver.org)

Business Office: [cindy.kane@grandriver.org](mailto:cindy.kane@grandriver.org)

ESL Program: [angela.thomas@grandriver.org](mailto:angela.thomas@grandriver.org)

School Nurse: [nurse@grandriver.org](mailto:nurse@grandriver.org)



# Guardian Information Form (International Students Only)

All international students must have someone that Grand River Academy can contact in the event of an emergency. We call this person the “guardian”. Ideally, this person will live in America and is often a family friend or relative.

**Student’s Name:** \_\_\_\_\_

**Guardian’s Name:** \_\_\_\_\_

**Relationship to Student:** \_\_\_\_\_

**Guardian Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Guardian Home Phone:** \_\_\_\_\_

**Guardian Work Phone:** \_\_\_\_\_

**Guardian Cell Phone:** \_\_\_\_\_

**Guardian Email Address:** \_\_\_\_\_





# Arrival Flight Information (International Students Only)

**Preferred Airport to fly into: Cleveland Hopkins International**

**Student's Name:** \_\_\_\_\_

**Arrival Date:** \_\_\_\_\_

**Airline:** \_\_\_\_\_

**Flight Number:** \_\_\_\_\_

**Arrival Time:** \_\_\_\_\_

**Unless noted otherwise, Grand River Academy will plan on picking your son up at the airport.**