China Spring Youth Camp

Placement Packet

SECTION TO BE PROVIDED TO

PARENTS/LEGAL GUARDIANS

UPDATED: February 2026

225 China Spring Rd. Gardnerville, NV 89410
P.O. Box 218, Minden, NV 89423
Tele (775) 265-5350 or 265-5811 Fax (775) 265-7159

We have been informed your child was committed to China Spring Youth Camp. In an effort to facilitate the intake process, we are requesting the following documents be completed and given to your child's probation officer prior to his/her arrival.

We understand this may be the first time your child will be away from home for an extended period of time. Because of this, we understand you may have concerns about what we do at China Spring. Before asking for detailed information about your child, let us take a minute to explain what the China Spring program is about and what you and your child can expect.

China Spring Youth Camp is a progress based program where the youth's behavior and adherence to the rules will determine the length of time in the program. We are dedicated to helping mid-level offenders between the ages of 12 and 18 develop skills, knowledge and experience to promote health and resiliency, stop the progression of problems caused by delinquent behavior, interpret, and avoid high-risk behavior patterns in an emotionally safe, comforting, challenging and nurturing environment.

We have no bars on the windows or locks on the doors. We do have alarms and security policies, but our philosophy is one of honor, trust and accountability. We are dedicated to helping your child define whom they are and what they will do when released. We provide structure and programs to help your child become a productive member of your family and community.

The staff is available to assist you and your child. The Case Manager is the person who is responsible for your child's coordination of treatment and your child will be assigned a Case Manager upon arrival. The Case Manager is the staff with whom you will have the most contact. Your child is expected to follow the China Spring's rules which will help them progress through the program. Please note that this program focuses on progress rather than a set time frame. Active parent engagement is vital to your child's success, and we are committed to involving you throughout their time in Camp. Together we can create a supportive environment that fosters growth and development.

The following is a list of services and programing provided by the camp:

Medical Services

Your child will receive medical, vision, and dental care deemed to be in his/her best interest and directed by our facility nurse and/or doctor. You may be billed for services from medical entities who provide service to your child. If, at any time, your child feels ill, s/he should notify a staff member. They will immediately help your child with minor problems and initiate a referral to the facility nurse. The youth can also initiate a nurse request at any time during their time at China Spring Youth Camp. The facility nurse handles minor medical requests twice weekly. In the event your child needs more serious attention, we will refer him/her to the facility's doctor. In all cases, when a referral is made to a medical doctor, you will be notified and will be asked to provide transportation to a medical doctor of your choosing. We will also use the best qualifying facility for your child's dental and vision needs, this will vary depending on your child's specific situation. If it is an emergency, or you are not physically able to transport your child to a physician of your choosing, the facility may provide transportation. For this reason, the attached medical information sheet must be filled out in its entirety. Please be informed that the facility will provide the insurance information to the service provider. Any costs not covered by insurance will be the responsibility of the parent/guardian. All prescriptions will be filled at the Walmart Pharmacy. The parent will be relied on to help with medical, dental and vision transports when your child is in the Transition Stage of the program. As they transition back to your care, so will their medical needs. It will be your responsibility to provide any needed OTCs on their home visit passes during the last stage of the program. If your child is on a prescription medication that requires monthly management by a professional, your child will be seen by our contracted personnel. You can be phoned into these visits if you would like to be involved. Any proposed changes to medications will require your written consent.

Medical Costs

Please remember that the parent or guardian will be responsible for the costs associated with treatment and services for any health condition that existed before the child's placement at China Spring Youth Camp, regardless of whether your insurance covers the services during your child's stay at Camp. Depending on the circumstances, other medical costs may also be billed to the parent or guardian. When possible, Camp will work with you to establish your child as a patient with new providers and to schedule appointments. You will typically be billed directly by the provider.

Educational Program

Your child will be required to participate in an educational program as part of his/her individual treatment plan. The educational program is operated by the Douglas County School District through Jacobsen High School. Credits your child earns will be transferable to the school s/he attends after leaving the facility. The Jacobsen High School staff with input from your child's Case Manager will develop educational goals. Your child will be taking a placement test upon his/her arrival into the facility. This test along with a review of your child's past school history, the completion of a personal interview with your child, your input, and your child's input will be used to formulate the most appropriate educational plan.

Wilderness Program

A wilderness program fosters personal growth through outdoor adventures, teamwork, skill building, promoting resilience, self-discovery, and connection with nature. Your child may be involved with the wilderness program. The Wilderness Program includes activities such as hiking, swimming, camping, fishing, rafting, trail construction, snow shoeing, and cross-country skiing.

Youth Development System

The basic program of the facility, called the Youth Development System, is based upon psychosocial principles of adolescent growth. The Youth Development System is designed to help your child learn, grow, and experience progress while also providing a system of rewards and incentives for behavior we want to reinforce. As such, the Youth Development System is directed at achieving positive changes in your child's attitudes, values, thinking processes, as well as behavior.

The China Spring Youth Camp utilizes a system for tracking your child's progress throughout the Youth Development System program, which is divided into three stages. The stages are designed to provide structure, guidance, support and feedback concerning your child's behavior and progress in the program. It is designed to grant increased responsibilities and privileges, maintain motivation and increase self-esteem as your child progresses through the program and toward his/her eventual return to the community.

Orientation Stage

The orientation stage refers to the initial phase where your child will acclimate to China Spring's environment. During this time, they adapt to new routines, build relationships with staff, and learn Camp rules/expectations. This stage is crucial for establishing a sense of safety, belonging, and setting the foundation for personal growth/development throughout the program. It is expected that your child will remain in Orientation Stage approximately 30 to 45 days.

It is important to note while your child is in Orientation Stage you will not have any phone contact or visits until s/he has been here for 30 days or promoted to the next level whichever comes first. However, your child is encouraged to write letters to family and can receive letters as early as his/her first day in the facility. Additionally, on the day your child arrives to Camp, you will receive a phone call from their assigned case manager and your child informing of arrival and will have the opportunity to ask any questions about the program.

Adjustment Stage

Your child will be expected to actively engage in personal development activities, guided by their individualized treatment plans. This includes:

- Skill Building: Focus on developing specific skills through various programs and workshops tailored to their needs.
- Teamwork and Collaboration: Emphasis on working together in group activities to enhance communication and cooperation.
- Self-Reflection: Encouraging participants to reflect on their experiences, set personal goals, and identify areas for growth as outlined in their treatment plans.
- Increased Responsibility: Providing opportunities for participants to take on more responsibilities, promoting independence and accountability.
- Emotional Growth: Fostering emotional resilience by navigating challenges and learning to manage feelings effectively, in alignment with their therapeutic goals.

Overall this phase aims to deepen their engagement and facilitate meaningful personal and social development while ensuring progress on their treatment plans.

Transition Stage

The aim of the transition stage, where your child can return home on the weekends, is to facilitate the integration of skills learned in Camp into their home environment.

- Reinforcement of Skills: Allowing youth to practice coping strategies and interpersonal skills with family members.
- Family Engagement: Encouraging open communication and involvement of family in the treatment process to strengthen support systems.
- Real-Life Application: Providing opportunities for youth to apply what they've learned in a familiar setting, helping them adapt their new skills to everyday life.
- Monitoring Progress: Assessing how well youth can manage challenges at home, which helps inform future treatment planning.
- Building Confidence: Boosting self-esteem as youth demonstrate their ability to navigate home life while applying positive behaviors

Leadership Program

The Leadership Program is where select residents demonstrate readiness to take on greater responsibilities and mentor their peers. Not every resident reaches this stage, as it requires:

- Demonstrated Growth: Participants must show significant progress in personal development, emotional regulation, and interpersonal skills.
- Peer Mentorship: Residents in this stage are encouraged to guide and support others, fostering a sense of community and teamwork.
- Leadership Skills: Engaging in activities that enhance leadership abilities, such as problem-solving, decision making, and conflict resolution.
- Role Modeling: Acting as positive role models for younger or less experienced residents, showcasing the values and behaviors promoted throughout the program.
- Goal Setting: Collaborating with staff to set advanced personal and professional goals, furthering their development.

Contraband

Your child may not be in possession of any item not specifically listed on the required belongings list in this packet. We understand there may be times when you want to bring or send your child "treats" or gifts, but your child will not be allowed to receive these. Administration or counselors will give you special instructions to follow during the holidays. Exceptions are not made for birthdays or other occasions. Your child may not carry or have in his/her possession any money, food, gum, or any other item not approved by the facility's administration.

Visiting

During your child's stay, you will have an active role in your child's treatment program. As such, visitation privileges are offered in a fashion consistent with your child's behavior and progress in his/her treatment plan. In-facility family visits will be limited to parents, grandparents, and/or legal guardians only. Visiting will be allowed once per week if the resident is not eligible for a home pass. The Case Manager will call and inform you have visiting hours. Your presence in the facility must be pre-approved through the Case Manager.

Exceptions to the visiting guidelines are rarely granted and are to be requested to the Case Manager. Due to resource demands, your child's phone call will be limited to ten minutes which will be initiated by Camp staff. As with in-facility visits your child may only speak to parents, grandparents, and/or legal guardians, and court appointed advocates.

Family Systems Course (Targeted Case Management/Family engagement)

Both you and your child will be assigned a case manager. Case management is designed to support youth by coordinating tailored services to meet individualized needs.

- Assessment: Identifying the specific needs and strengths of the youth and their family.
- Planning: Developing a comprehensive service plan that outlines goals and necessary resources.
- Coordination: Connecting families with various services, such as mental health support, educational resources, and community programs.
- Monitoring: Regularly reviewing progress and adjusting the plan as needed to ensure effectiveness.
- Advocacy: Acting as a liaison between the youth, family, and service providers to ensure the youth receives appropriate care.

The Parent Support Group meets every Friday from 5pm-6pm at Camp to provide a nurturing environment for parents and guardians. This group offers a space for sharing experiences, challenges, and successes related to their children's journeys. Led by trained facilitators, discussions focus on effective communication strategies, coping mechanisms, and resources available to support families. Participants can connect with others facing similar situations, fostering a sense of community and understanding. The group aims to empower parents, enhance their support skills, and encourage collaborative approaches to promoting their child's growth and well-being throughout their time at Camp. Participation is mandatory and reported to Probation and the Courts monthly.

Mail

Your child will be allowed to correspond with parents/guardians, family members, lawyers, court appointed advocates, and Probation Officer. The suggested list is not inclusive and may consist of additional individuals who have a direct positive influence upon your child. Mailing address is : 1640 US Hwy 395 N #2605 Minden, NV 89423

If you have questions or concerns, please do not hesitate to contact the facility. Your questions/concerns will be directed to those best able to address the issue.

(Please keep this letter for your reference)

DAILY SCHEDULE

The following is an example of the schedule your child will follow on any given day:

Wake Up	6:00 a.m.
Breakfast and med call	6:15 a.m. to 6:55 a.m.
Chores and/or Group Counseling	6:30 a.m. to 7:15 a.m.
School Begins and/or Group Counseling	7:20 a.m. to 11:20 a.m.
Lunch and med call	1125 p.m. to 1200 p.m.
School Resumes	1:30 p.m. to 2:30 p.m.
Group counseling/physical fitness	2:30 p.m. to 5:00 p.m.
Dinner and med call	5:00 p.m. to 6:00 p.m.
Downtime /Counseling	6:00 p.m. to 7:00 p.m.
Showers/Chores	7:00 p.m. to 8:00 p.m.
Hygiene, wind down, and med call	8:00 p.m. to 9:00 p.m.
Lights Out	9:00 p.m.

VISITING RULES

Please remember this is a controlled environment and the rules are necessary for a safe, secure facility.

1. Photo ID (i.e. Driver's License) is required upon arrival.
2. Friday visits are from 4:00 p.m. to 5:00 p.m. for both facilities.
3. Parents/Grandparents/Guardians, ONLY, are allowed to visit.
4. Any visitor under the influence of an intoxicant will not be allowed on Facility property. Local law enforcement will be notified.
5. All visitors are subject to search.
6. No unauthorized visitors are allowed on facility grounds.
7. Visitors must park in the designated parking area.
8. Case Manager will inform where to go for visiting
9. Visitors may not give anything directly to a resident. If you have something for a resident, it must be given to staff immediately upon arrival.
10. The following are not allowed under any circumstance:
    - Food
    - Beverages (this includes water bottles)
    - Cell Phones
    - Weapons
    - Prescription Drugs
    - Illegal Drugs
    - Purses or bags
11. China Spring is a NON SMOKING facility pursuant to NRS 202.2491.
12. You must provide vehicle information, including license plate number upon arrival.

Violations of the visiting rules will result in future visits, passes or other privileges to be forfeited by you as the guardian or by your child. The rules are clearly known and violations will not be tolerated.

Personal Belongings Supply List

1. **All clothing must be sized to fit your child, baggy clothing will not be accepted. Clothing must be plain and logo free. Please avoid large and colored logo on shoes. All items should be black, grey or white (neutral)**
2. **All hygiene items are to be in plastic containers, non-aerosol and non alcoholic. Perfume scents and expensive items are discouraged and will be likely refused. Items should have intact labels. No over the counter medications are accepted without a current doctor order.**

Please supply the following for the youth for the duration of their stay:

Hygiene/Health	Writing Materials/Misc	Footwear	Clothing
Deordorant (3)	Pencils (I pack non mechanical)	Slippers (1 pair)	Sweat pants (2)
Shampoo (2)	High Lighter (2)	Work Boots- no steel toe (1 pair)	Sweat shirt- no hood (2)
Conditioner (2)	White Binder (3)	Work Gloves (1 pair)	Lounge shorts (2)
Toothpaste (3) Toothbrush (1)	Paper (3 packs) no spiral	Running shoes (1 pair) Please prioritize	Athletic socks (12)
Bar of soap (2) Soap holder (1)	Family pictures (5)	Shower shoes (1 pair)	Underwear (12)
Body wash (2) Lotion (1)	Stuffed Animal- small		T-shirts (7)
Lip Balm (6)			Pajamas- modest (2)
Kleenex (1)			Winter Coat- seasonal (1)
Towel (2)			Beanie- seasonal (1)
Wash cloth (2)			Baseball style cap or bucket hat (1)
Comb or Brush (1)			Swim suit-seasonal (1)
Fash wash- acne ok			Bra- no wires
Hair ties (1 pack non metal) if applicable			Long Johns top and bottom (2) If during winter
Feminine hygiene (2) if applicable			Winter gloves (1) If during winter
30 day supply of prescription meds.			

Clothing

- 7 Under shirts (black/white/grey/tan)
- 7 Pairs of underwear (black/white/grey/tan)
- 7 Pairs of socks (black/white/grey)
- 2 Sweaters
- 2 Pairs sweatpants
- 2 Athletic shorts (black/grey)
- 1 Pajama pant
- 1 Winter Jacket
- 1 Hat (beanie or ball cap depending on the season)
- 1 Swimsuit

Girl's Dorm Specific Items

- 2 Wire-free bras (black, white, grey, tan)
- 2 Sports Bra (black, white, grey, tan

HIPPA PRACTICES

Effective August 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

You are receiving this notice in accordance with the Health Information Portability and Accountability Act (HIPAA), a federal law that governs the privacy of your health information. You are receiving this notice because China Spring Youth Camp, an entity of Douglas County, provides limited health care services to youth at the facility through contracted medical professionals.

WHO WILL FOLLOW THIS NOTICE?

This notice describes the information privacy practices followed by China Spring Youth Camp.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you may receive while at China Spring Youth Camp. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose your health information and describes your rights and our obligations regarding the use and disclose of that information.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

For Treatment

We, along with any physicians and other medical professionals who provide you with care, may use your health information to provide you with medical treatment or services. They may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems, which could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in their offices may share information about you and disclose information to people who do not work in the office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you, which we have.

For Payment
We, along with any physicians and other medical professionals who provide you with care, may use and disclose health information about you so the treatment and services, including those services received at China Spring Youth Camp, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information about a service you received to your health plan administrator so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations
We, along with any physicians and other medical professionals who provide you with care, may use and disclose health information about you in order to run our facility and make sure you receive quality care. For example, your health information may be used to evaluate the performance of medical staff contracted by China Spring Youth Camp in caring for you. Health information about all or many of our residents may also be used to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders
We may contact you as a reminder your child has an appointment for treatment or medical care at the office.
Treatment Alternatives
We may tell you about or recommend possible treatment options or alternatives, which may be of interest to you.
Health-Related Products and Services
We may tell you about health-related products or services which may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that do not wish to receive such communications, we will not use or disclose your information for these purposes. **Please note that your information will not be shared for marketing purposes or be sold without your written permission.**

You may revoke your discloser information consistent with the above policies at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that already occurred. If you revoke your Consent, we cannot use or disclose your information for purposes of treatment, payment, or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS
We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Address Public Health or Safety Issues
We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Required by Law
We will disclose health information about you when required to do so by federal, state or local law.

Research
We may use and disclose health information about you for research projects which are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information, which reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donating bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence
If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other governmental authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities
We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement
We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors
We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable
We may use or disclose health information about you in a way which does not personally identify you or reveal who you are.

Family and Friends
We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences, which are in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OR HEALTH INFORMATION
We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed and written authorization (different from the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed consent and a special written Authorization, which complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information that we maintain:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask the denial be reviewed. If law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend this information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information which:

1. We did not create, unless the person/entity which created the information is no longer available to make the amendment;
2. Is not part of the health information we keep;
3. You would not be permitted to inspect and copy;
4. Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing. The request must state a time period, which may not include dates more than six years prior to your request. Your request should indicate in what form you want the list (for example, on paper, or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask we not use or disclose information about a surgery you had. **We are not required to agree to your requested restrictions.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the "Request for Restriction on Use/Disclose of Medical Information".

Right to Request Confidential Communication

You have the right to request we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice, even if you have agreed to receive it electronically, and can ask us to give you a copy of this notice at any time. To obtain such a copy, contact the China Spring Youth Camp Director.

Right to Choose Someone to Act for You

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of this notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. More information can be found by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. To file a complaint with our office, contact the China Spring Youth Camp Director. You will not be penalized for filing a complaint.

NON-DISCRIMINATION NOTICE

In accordance with Federal Civil Rights Law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint For, (AD-3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. *Mail: U.S. Department of Agriculture*
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410

2. *Fax: (202) 690-7442; or*

3. *Email: program.intake@usda.gov*

This institution is an equal opportunity provider.

Attention Parent: Pages 1-10 of this packet are yours to keep. The following pages need to be reviewed, signed and submitted to the Juvenile Probation Office to be provided to Camp at the time of intake.

This Section Contains Forms to be Completed by Parent/Guardian and Submitted to Camp prior or at the time of Intake by the JPO.

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize China Spring Youth Camp, an entity of Douglas County, to use and disclose my medical information for the purposes of Treatment, Payment, and Health Care Operations.

Treatment includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by a physician who provides services by telephone as an on-call physician.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities, which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

Health Care Operations includes the necessary administrative and business functions of China Spring Youth Camp, and the offices of the medical professionals with whom we contract.

You have the right to revoke this Authorization at any time, provided you do so in writing and except to the extent we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review the "Notice of Privacy Practices," available from the China Spring Youth Camp Director, for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will provide you a copy of the Notice then in effect with your intake paperwork. We will also provide you with a copy of the Notice then in effect upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Physicians and other medical professionals who provide services to China Spring Youth Camp are required to use and disclose your protected health information consistent with the Notice.

I understand I have the right to revoke this Consent provided I do so in writing, except to the extent China Spring Youth Camp has already used or disclosed the information in reliance on this Consent. I further understand that I have the right to examine the Notice of Privacy Practices and receive a copy of said Notice upon request.

_____ _____

Signature of Resident or Person Authorized by Law Date

HIPAA

CHINA SPRING YOUTH CAMP
AUTHORIZATION FOR RELEASE OF INFORMATION

Child's Name: _____ Date of Birth: _____

I understand my records are protected under Federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), and the restrictions regarding confidentiality of juvenile records as outlined in NRS Chapter 62H, and cannot be disclosed without my written consent unless otherwise provided for by law or regulation.

I also understand I may revoke this consent at any time except to the extent action has been taken in reliance on it, and in any event this consent expires automatically as described below.

I understand this consent authorizes either written or verbal transfer of the referenced information below. I waive on behalf of the above named child and myself all provisions of law relating to disclosure of confidential information, and release the Douglas County and China Spring Youth Camp from any liability, which may arise from this authorization.

I HEREBY AUTHORIZE:

A. Any physician, hospital, institution, psychologist, social worker, school, or state, county, and federal agency having appropriate medical, psychiatric, psychological, social case, educational, vocational, and/or employment records, reports and/or evaluations pertaining to the resident named below, to disclose such records to the China Spring Youth Camp, so they may process this case for medical services and/or treatment services.

B. The China Spring Youth Camp to release to any physician, hospital, institution, psychiatrist, psychologist, social worker, school or state, county and federal agency, any information pertaining to the resident named below which may be pertinent to a better understanding and more thorough evaluation of this medical service and/or treatment service.

C. The China Spring Youth Camp to prepare certified copies of this authorization for the purpose of obtaining information from multiple sources. Such copies are to contain the statement: "I CERTIFY THIS COPY TO BE A TRUE COPY OF THE ORIGINAL", and be certified as to a true copy by the China Spring Youth Camp.

It is understood by the undersigned the authorization for disclosure contained herein shall include information pertaining to services and related benefits which may have been rendered or paid under any applicable health insurance coverage or any other health or medical protection plan, and any such information in the possession of any such provider of health or medical insurance coverage pertaining to the resident below may be disclosed to the China Spring Youth Camp.

I understand this authorization is valid while my son/daughter is a resident at China Spring Youth Camp and for a period of one (1) year after the discharge of the child.

_____ _____
Resident Parent/Guardian or Primary Caretaker

State of Nevada)
)ss
County of _____,)

On _____, 20__ before me, _____
(Notary's Name)

CONSENT FOR MEDICAL ATTENTION

I, _____, parent or legal guardian of

minor child, _____do hereby consent to any medical care determined necessary by China Spring Youth Camp staff and/or a medical service provider to be necessary for the welfare of my child while said child is under the care of China Spring Youth Camp. I further consent to disclosure of identifying information and medical history to the physician, nurses, emergency medical personnel or hospital evaluating my condition. I further give my consent for China Spring Youth Camp staff to give my child prescribed or over-the-counter medication on a daily and/or occasional basis. All medications will be administered according to the medications' label instructions. This consent shall terminate upon discharge from the program. In addition, I give my consent for China Spring Youth Camp to share communication with my current health provider including, but not limited to: physician, mental health provider, dentist/orthodontist, optometrist etc.

_____ _____

Parent/Guardian/Authorized Representative Signature Date

_____ _____

Witness Signature Date

MEDICAL INSURANCE INFORMATION SHEET

*Provide a legible copy of the front and back of your child's insurance cards (including dental and prescription if separate).

PRIMARY MEDICAL

Insurance Carrier: _____

Policy Holder Name: _____

SECONDARY MEDICAL If your child is covered by another insurance carrier, please complete the following

Insurance Carrier: _____

Policy Holder Name: _____

PRESCRIPTION COVERAGE

Prescription Carrier _____

Policy Holder Name: _____

DENTAL COVERAGE

Primary Insurance Carrier: _____

Policy Holder Name: _____

INSURANCE AUTHORIZATION

I, _____
(Print Name)

Authorize and assign China Spring Youth Camp and its representatives to use my insurance for the benefit of my Son/Daughter who is covered under said insurance policy. I also understand I am financially responsible for any cost not covered by insurance, including but not limited to deductibles, co-payment amounts and non-covered services. In accordance with NRS 628.110, when a child who is under the jurisdiction of the Juvenile Division of the District Court receives ancillary services administered or financed by Douglas County, including but not limited to, transportation or psychiatric, psychological, or medical services, the county is entitled to be reimbursed from the parent of the child for such services.

_____ _____
Guardian Signature Date

Over the Counter Medication Consent Form (OTC)

Name: _____ Date of Birth___/___/_____

Known Allergies:

_____

_____

Over the counter medications may be administered to your child by China Spring Youth Camp staff.

OVER THE COUNTER MEDICATIONS: (Please indicate with your initials each OTC that may be administered)

Symptoms	Medication	Parent Initial
Itching, rash	Hydrocortisone/Cortisone Cream- 4x Daily*	
Minor cuts, scrapes, burns	Neosporin/Antibiotic Ointment- 4x Daily*	
Cold Sore Treatment	Campho-phenique- 4x Daily	
Oral sore, canker sores	Orajel- 4x Daily Salt water swish 4x Daily	
Itching/burning feet	Anti-Fungal Cream- 2x Daily (B/N) for 30 days. Change socks with new medication and after sweating*	
Vaginal itching/burning	Vagisil/Feminine itch cream- 4x Daily	
Minor Burns	Burn cream *	
Sun Burns	Aloe Vera Gel	
Stye, eye infection	Stye Cream/ointment	
Cold Sore Treatment	Campho-phenique	
Heartburn/stomach ache	Antacids* Omeprazole- (1) Tablet Daily **Must have nurse order.**	
Stomach ache related to dairy	Dairy Relief	
Chapped lips, extreme dry/chapped skin	Vaseline/Petroleum Jelly/Aquaphor- 4x Daily	
Sore throat pain	Salt Water Gargle/Cough and Sore Throat Drop	
Sinus Congestion	Sinus Decongestion*	
Cough (no congestion)	Cough and Sore Throat Drop	
Cough and Cold	Cough and Cold Tablets *	
Severe Cold and Flu	Alka Seltzer*	
Common allergies runny nose, itchy throat, sneezing, itchy watery eyes	Allergy Plus Chlorphen* Loradatine	
Non-life threatening allergic reaction (IE Rash, minor swelling)	Diphenhydramine (1 tab)- Update Nurse on findings	
Diarrhea or symptoms of diarrhea	Anti-Diarrheal	
Nausea; vomiting	Stomach Relief	
Anti-inflammatory, pain reliever, headache reliever, fever reducer	Ibuprofen or Tylenol	
Constipation, hard stool	Stool Softener and Fiber Laxative **Must have nurse order**	
Ingrown toe nails, infected wounds on feet/hands	Epsom Salt/Soak- 2x daily	
Acne	1 dab iodine or 1 dab acne spot cream	
Dry/Irritated Eyes	Eye Drops	

By signing below, you are giving China Spring Youth Camp permission to administer the medications checked above as required and agree that all known allergies are listed above. You are also acknowledging that you will not hold China Spring Youth Camp or its staff responsible for any claims arising out of the implementation of the Center's Standing Medical Orders and/or treatment procedures for your child

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Date

_____ _____

Witness Date

DAMAGE RESPONSIBILITY NOTICE

I acknowledge that my child will be held financially responsible for any damage they may cause to Douglas County property during their residency at China Spring/Aurora Pines. This includes, but is not limited to, any intentional or unintentional harm to facilities, equipment, or any other property.

I understand that the camp will assess the damage and determine the costs associated with repairs or replacements. This will ensure that the camp can maintain a safe and welcoming environment for all residents.

Guardian Signature: _____ Date: _____

PUBLICITY WAIVER/RELEASE FORM

Parent/Legal Guardian Information

Name: _____
(Print)

Child's Name: _____
(Print)

Permission Statement

Please check one option:

☐ GRANT permission for my child's name or picture to be used in connection with activities, including but not limited to: wilderness trips, intramural athletics, organized sports, or charitable, social, or publicity events associated with China Spring/Aurora Pines.

☐ DO NOT GRANT permission for the use of my child's name or picture in the aforementioned activities.

By signing this form, I waive any restrictions regarding the confidentiality of juvenile records as outlined in NRS 62.355.

Guardian Signature: _____ Date:_____

PROGRAMS AND ACTIVITIES
PERMISSION, RELEASE AND INDEMNITY AGREEMENT

Child's Name: _____ _____
Date

I, _____ am the parent, or have been
(Print Guardian Name here)

appointed legal guardian by court order, of the above named minor child.

I further state, the above named minor child is physically able to participate in the activities selected below:

Initial

☐ I give permission for the above named minor child to participate in the Recreational Programs and Activities of the Camp, which includes but is not limited to football, basketball, volleyball, baseball, yoga, swimming, and other recreational activities in and about the Camp and Community.

☐ I further give permission for above named minor child to participate in the activities of the Camp's Wilderness Program, which includes but is not limited to hiking, basic mountaineering, survival techniques, swimming, backpacking, camping, ropes course, cross-country skiing, snowshoeing, rafting, kayaking, and fishing, in and about the Camp, Wilderness Areas and Parks of Nevada and California. As such, I further give permission for the above named minor child to be taken by Camp Staff to the state of California for the purpose of participating in said activities.

☐ I further give permission for the above named minor child to participate in the activities, training and care of animals within the Camp's Animal Program, which includes but is not limited to dogs, birds, and any other domestic animal(s), which may be in and about the Camp and Community.

I have been advised of the various dangers that the above named minor child may be exposed to during their participation with these programs, which includes but is not limited to severe weather conditions, physically demanding conditions, and unanticipated animal-caused injuries. I also acknowledge that I have been advised that the above named minor child may be exposed to actions, events, and environments that may be hazardous to his/her person and/or property, including danger to life and/or limb. I understand that I am solely responsible for any medical costs that may directly or indirectly result from my child's participation in the above program(s).

NOW, THEREFORE, having been fully advised of the dangers inherent to these various program(s) in which I grant permission for the above named minor child to participate in, I do hereby, for the above named minor child, myself, my spouse, heirs, executor or administrator, and personal representatives:

- Assume the risks of the minor child participating in said programs and take full responsibility for any personal injury, including death, to the above named minor child, which may occur directly or indirectly, associated with the above named minor child's participation in the various programs mentioned above.
- Fully and forever release and discharge China Spring Youth Camp, Douglas County, the Ninth Judicial District Court, and the officers, employees, agents and servants of these entities, from any and all claims, demands, damages, rights of action, or causes of actions, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the above named minor child's participation in the various programs mentioned above, whether resulting from the negligence of the above named entities and the agents thereof or otherwise.

- Agree to indemnify and hold harmless China Spring Youth Camp, Douglas County, the Ninth Judicial District Court, and the officers, agents, employees and servants of these entities, with respect to any and all claims, injuries, and costs associated with my child's participation in these program(s).

- Agree to defend and to pay any attorney's fees or associated costs as a result of any claim or action brought against China Spring Youth Camp, Douglas County, the Ninth Judicial District Court, and the officers, agents, employees and servants of these entities, for any acts or conduct on the part of the above named minor child of whatever kind or nature whatsoever, while in, on or about any such Douglas County vehicle, or at any and all Douglas County premises or facilities.

- Agree that it is my intent, having read and having been fully informed of all of the above that this Release and Indemnity Agreement be in full force and effect at any time after the execution hereof.

In case of an emergency, please notify:

_____	_____
Name	Name
_____	_____
Telephone Number	Telephone Number

I further agree, in case of injury and/or illness, the Camp staff shall have authority to act in the child's best interest.

_____
Relationship to Child

_____	_____
Signature of Parent / Legal Guardian	Date

Address: _____ Telephone Number

_____ _____

_____

Dated this date _____day of _____, 20_____, at _____o'clock.

*A valid photo identification of the applicant and the parent or guardian (if applicable) shall be presented to and a copy of shall be attached to this agreement.

C.H.O.I.C.E.S. PROGRAM MEDICAL INFORMATION FORM

1) Are there any physical limitations, which would prevent full participation, including:

- ☐ Disabilities
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Conditions
- ☐ Recent Injuries
- ☐ Recent Illness
- ☐ Allergies (Food)
- ☐ Allergies (Medication)
- ☐ Allergies (Insect, etc.)
- ☐ Menstrual Problems
- ☐ Venereal Disease (STD)
- ☐ Pregnancy (Current)
- ☐ Pregnancy (Recent)
- ☐ Tuberculosis
- ☐ Migraine Headaches
- ☐ Asthma/Breathing Problems
- ☐ Sprains/Dislocations
- ☐ Concussion/Head Injury
- ☐ Chronic Cough
- ☐ High Blood Pressure
- ☐ Back Pain
- ☐ Bedwetting/Incontinence
- ☐ Motion Sickness
- ☐ Urinary Tract Infections
- ☐ OTHER? _____

PLEASE EXPLAIN ANY ABOVE PROBLEM (Dates, Frequency, Severity, Extent of Limitation)

_____

_____

_____

2) Are there any psychological tendencies, which we should be aware of (fear of heights or water, suicide attempts, drug/alcohol addiction, depression, etc.)?

_____

_____

_____

3) Please list all prescription drugs, which the child is required to take, as well as the doctor who prescribed them, and the amount/frequency of administration. Staff will hold these for the duration of the trip. PLEASE BE SURE TO SEND YOUR CHILD'S MEDICATION WITH THEM, IN A SUFFICIENT AMOUNT TO LAST FOR THE DURATION OF THE TRIP.

_____

_____

_____

4) Wilderness Program staff carry a well-stocked first aid kit at all times, which contains the following over-the-counter medications Please check those medications, which you, as parent or legal guardian, give us permission to administer to your child in the event of illness:

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil, Midol)
- ☐ Diphenhydramine (Benadryl)
- ☐ Dramamine (Motion Sickness)
- ☐ Pepto-Bismol
- ☐ Rolaids/antacid
- ☐ Pseudoephedrine (Sudafed)
- ☐ Mylanta/laxative

Signature of parent/guardian _____ Date _____

5) The Wilderness Program staff has been trained in the administration of *EPINEPHRINE* (a prescription drug), which reverses the effects of severe life threatening systemic (whole body) allergic reactions to substances such as bee stings or food allergies. An individual's past history is often not a reliable indication of future reactions. Therefore, we request permission to administer *EPINEPHRINE* in the event your child has a life threatening allergic reaction while in our care

I/We _____ give CAMP Wilderness Program Staff permission to administer

EPINEPHRINE to _____ in the event of a systemic allergic reaction.

PLEASE CONTACT US IF ANY INFORMATION CHANGES OR DEVELOPS

COMMITMENT FACE SHEET

(Please fill out ALL information completely)

Juvenile's Name _____

Social Security Number _____ Is your son/daughter _____

Date of Birth _____ Currently receiving income? _____

Age _____ Current Grade _____ ☐ Yes (list Income) _____

Birthplace _____ ☐ No

Religious Affiliation _____ Race/Ethnicity _____

Hair _____ Height _____ Tattoos _____

Eyes _____ Weight _____ Scars _____

Guardian at Commitment _____ Relationship: _____ Date of Birth _____

Phone Numbers: Home _____ Work _____ Cell _____

Mailing Address _____ City _____ State ____ Zip _____

Physical Address _____ City _____ State ____ Zip _____

Employment _____ SSN _____

Driver's License # _____ State _____ Expiration _____

Other Parent/Guardian _____ Relationship: _____ Date of Birth _____

Phone Numbers Home _____ Work _____ Cell _____

Mailing Address _____ City _____ State ____ Zip _____

Physical Address _____ City _____ State ____ Zip _____

Employment _____ SSN _____

Driver's License # _____ State _____ Expiration _____

Financial Info

Income of Parent(s)		**Expenses**	
Monthly Gross	_____	House Payment/Rent	_____
Child Support	_____	Medical Bills	_____
State Assistance	_____	Utilities	_____
Food Stamps	_____	Additional Monthly Bills	_____
Disability	_____		

Spanish Speaking Household? Yes / No

Vehicle Information: List all vehicles in which you may drive to the facility for visits and used to transport a resident in and out of the facility at any other time.

Make	Model	Color	License Plate #

Zero Tolerance Policy

China Spring Youth Camp has a Zero Tolerance Policy against all forms of sexual abuse and sexual harassment. The protection of the facilities youth against all forms of sexual abuse and sexual harassment is important. All employees, staff, residents, contract employees, contract services personnel, volunteers and visitors are subject to the Zero Tolerance Policy.

How do I report sexual abuse and/or sexual harassment?

Residents of the facility have the right to report sexual abuse and/or sexual harassment free of retaliation and consequence. Reports can be filed in the following ways:

1) Tell a trusted staff member, request a supervisor, or request to speak to a member of Administration. Administration accepts phone calls 24 hours a day.
2) Complete a Grievance form and place in the secured box.
3) Ask staff to make a private phone call and contact one of the listed outside agencies provided during intake.
4) Use the dorm phone to select a pre-programmed number:
    a. Line 1: Internal PREA Message Line for PREA Compliance Manager. This is checked by message and email by the PREA Compliance Manager.
    b. Line 2: Contact Family Support Council for Victim Services, Emotional Support, or to contact your designated advocate. 775-782-8692.
        i. Physical Address: 1255 Waterloo Lane, Gardnerville, NV 89410
        ii. Mailing: P.O. Box 810 Minden, NV 89423
    c. Line 3: Contact the Reno Crisis Call Center 1-800-992-5757
        i. 900 N. Virginia St. Reno, NV 89557
    d. Line 4: Douglas County Sheriff's Office Investigations 775-782-9905
        i. Mailing Address: P.O. Box 218 Minden, NV 89423
5) Residents may also request a private phone call to their parents, JPO, attorney, or other guardian.
6) Parents/Guardians or other third parties may report on behalf of a resident using any of the contact numbers provided on the website, including contacting Douglas County Sheriff's Office.

Additionally, the PREA Compliance Manager or designee will provide on-going PREA Education to residents of China Spring Youth Camp about their protection from sexual abuse and sexual harassment. The curriculum will be designed to be age appropriate and take into consideration any limitations the resident may have.

Physical: 225 China Spring Rd, Gardnerville, NV 89410
Mailing: 1640 US HWY 395 N #2605 Minden, NV 89423
Tele: (775) 265-5350 or 265-5811 Fax: (775) 265-7159

Parent Commitment Agreement for China Spring Youth Camp

This agreement outlines the responsibilities and commitments of parents/guardians whose child is enrolled at China Spring Youth Camp. By signing this document, parents/guardians acknowledge and agree to the following conditions:

1. Parent Support Group Participation As a Parent/guardian, I agree to attend Parent Support Group sessions following my scheduled visit with my child at camp. This session is designed to support you, as a parent, during your child's time at the camp and to help foster a positive relationship between camp staff and families.

2. Transition Pass Requirement Before taking your child home on a transition passes, you are required to attend the Parent Support Groups. These groups are vital to ensure a smooth transition and to discuss the next steps in the child's development and integration.

3. Commitment to Program Participation By signing this contract, you are committing to fully engaging in the above processes, understanding that your participation is crucial to the success of your child's experience at China Spring Youth Camp.

4. Acknowledgment of Agreement By signing this document, I acknowledge that I have read, understood, and agree to adhere to the above terms for the benefit of my child and their successful experience at the camp.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Date: _____

China Spring Youth Camp
Serving Nevada's Youth

225 China Spring Rd, Gardnerville, NV 89410
P.O. Box 218, Minden, NV 89423

Tele: (775) 265-5360 or 265-5811 Fax: (775) 265-7159

Visitor Guidelines

Dear Visitors- Please review the following guidelines of our facility and ask questions if necessary.

1. No cell phone allowed in the building.
2. You must present a photo ID to staff and sign in on the clip board to include driver's license and expiration.
3. Guests are not allowed under any circumstances to open a door to the facility for another guest whether their coming in or out. This poses a safety and security issue. No opening of doors or windows without permission from staff.
4. No outside items including but not limited to purses or wallets allowed inside the building.
5. No outside food or drinks, including gum or candy.
6. No weapons allowed including pocket knives, guns, multi-tools
7. All items coming into the facility for a resident must be pre-approved by staff.
8. Keep physical contact to a minimum. Staff reserves the right to inform visitors if this should become an issue.
9. Please be aware you are sharing the visiting room with other families, keep the noise to a minimal level.

Be aware that you are under surveillance and being recorded.

Important: When signing the Visitor Log at each visit, you are agreeing to comply with all rules while at the Facility.

Visitor Signature:_____ Date:_____

Staff Signature:_____ Date:_____

CHINA SPRING
SERVING THE YOUTH OF NEVADA

Physical: 225 China Spring Rd, Gardnerville, NV 89410
Mailing: 1640 US HWY 395 N #2605 Minden, NV 89423
Tele: (775) 265-5350 or 265-5811 Fax: (775) 265-7159

Home Pass Acknowledgment Form

Youth's Name: _____
Date: _____

As the parent/guardian of the youth named above, I hereby acknowledge that I have received, reviewed, and understand the expectations and rules associated with my child's home pass. I agree to adhere to these rules and ensure that my child follows the necessary guidelines for their weekend pass.

By signing below, I confirm that I fully understand and agree to the rules and expectations outlined above for my child's home pass. I acknowledge that failure to adhere to these rules may result in the revocation of the home pass or other disciplinary actions.

Parent/Guardian Name: _____

Signature of Parent/Guardian: _____
Date: _____

Case Manager Signature: _____
Date: _____

225 China Spring Rd, Gardnerville, NV
89410
1640 US Hwy. 395 N. #2605, Minden
NV 89423

TEMPORARY RELEASE RULES

All residents of China Spring Youth Camp are under the guardianship of the director of this camp. When a resident is temporarily released from the camp for any reason s/he is still responsible for following facility rules.

Failure to follow temporary release rules will result in disciplinary action, loss of privileges and/or affect program length

☐ Medical Appointment/Special Pass

Out of camp appointments may be granted for the purpose of allowing the parent to take an active role in their child's health or legal situation. Special passes may also be granted per Administration approval.

- Residents are not to go home
- Return at specified time
  No contact with unauthorized persons.
  No contact with friends
  100% sight supervision
  No tobacco/nicotine products, i.e. vapes, "Juuls", pouches, cigarettes, etc.
  No alcohol
- No illicit drugs
- No driving
- No items may be brought into the facility without approval
- All stops (including meals) must be approved. Meal receipts must be turned into staff upon return.

☐ Home Visit

Home visits are granted so the family can spend quality time together. As such, visiting with friends is restricted according to your child's stage, please see below for requirements.

- House Arrest, 100% sight & sound supervision by parent(s)/guardian(s)
- Return at specified time
- **Transition:** No friends may visit & no phone calls to/from friends without prior approval from Case Management.
- All rules of probation apply (no contact with residents/ex-residents of the facility or those on probation/parole)
- No altering of appearance (hair color, piercing, tattoos, extreme haircuts/styles). May wax tweeze eyebrows - No gang related styles.
- Males: Must have pre-approval from CM/Supervisor approval to get a haircut and it must be within camp guidelines. This includes trims, touchups, fades, shaving of head, etc.
- Females: Make up and jewelry is approved, but must be removed prior to arrival to camp Must have CM/Supervisor approval for haircuts & color.
- No tobacco/nicotine products, i.e. vapes, "Juuls", pouches, cigarettes, etc.
- No alcohol and no illicit drugs
- No driving/operating motor vehicles (ATV/Dirt Bike, etc.)
- Extreme sports need approval through Supervisor/CM.
- No items may be brought into the facility without approval
- Resident is prohibited from consuming any type of energy drink.
- Must call to check in three times daily between 6:00am and 10:00am, 1:00pm and 4:00pm, and 6:00pm and 10:00pm, including the day you leave and the day you return. Please call (775) 265-5350, dial appropriate extension for your dorm (i.e. 145- Girl's Dorm & 135- Boy's Dorm). If no one answers, leave a message including name, Camp#, date and time. Failure to check in will result in shortening of home pass or other additional consequences.

Please remember your child has been placed in a juvenile treatment center and although you may not agree with the rules outlined above failure to follow them will affect your child. Do not deviate from the above rules to allow your child a "chance to earn trust". Those opportunities will come later. Your child's manipulation of the rules will be viewed as a violation and, additionally, your attempt to circumvent the rules will be seen as a violation and will affect your child's program. Please be aware we will hold your child accountable regardless of who is responsible. This includes but is not limited to failure to return at the specified time.

Parent's Signature

Resident's Signature

China Spring Youth Camp
Serving Nevada's Youth

225 China Spring Rd, Gardnerville, NV 89410
P O Box 218, Minden, NV 89423

Tele: (775) 266-3350 or 266-3811 Fax. (775) 265-7159 Fax.

REGLAS DE SALIDA TEMPORAL

Todos los residentes de la facultad de China Springs/Aurora Pines están bajo la tutela del director de este campamento. Cuando un residente se le da libertad temporalmente del campamento o cualquier razón él/ella es responsable por los siguientes reglamentos de la facultad.

Fracaso de seguir los reglamentos de esta libertad temporal serán el resultado de la acción de disciplina, perdida de privilegios y/o afectara la longitud de la programa.

☐ Pase de citas/visitas especiales

Las citas fuera del campamento pueden ser garantizadas con el propósito de dejar al padre tomar una activa participación en el salud o las situaciones legales del joven.

- Residentes no pueden ir a su casa.
- Tienen que regresar a un tiempo específico.
- No debe de tener ningún contacto con personas que no han sido autorizadas.
- No puede tener contacto con amigos.
- 100% supervisión.
- No productos de tabaco.
- No alcohol.
- No drogas.
- No puede manejar.
- NO puede traer articulos a la facultad que no han sido aprobados.
- Todas las paradas (incluyendo comidas) tienen que ser aprobadas y los recibos de la comida tienen que ser otorgados al personal inmediatamente al regresar al campamento.

☐ Visita a la casa

Las visitas a la casa son garantizadas para que la familia pase tiempo junto De lo cual, las visitas de amigos están impedidas de acuerdo con la etapa de su hijo/a, por favor vea los siguientes requisitos

- Arresto de la casa es 100% supervisión de vista y sonido por los padres o guardianes
- Regresar a un tiempo específico
- **Transición:** No puede recibir visitas de amigos/as
- **Honor:** un amigo/a puede visitar con la supervisión del padre, no puede tener visitas durante la noche y debe de ser de género apropiado
- Las llamadas, mensaje de texto tienen que ser aprobadas por el padre o guardián
- No My Space/Facebook, snapchat o redes sociales
- Todos los reglamentos de probación son aplicab.es (no pueden tener contacto con residentes de la facultad o residentes que están en probación de libertad condicional)
- No puede alterar su apariencia personal (color de cabello, perforaciones, tatuajes, corte de cabello extremoso e ilícito.
- **Tanto los hombres como las mujeres:** solamente pueden ponerse aretes No otras perforaciones o gauges No puede traer las joyas al campamento
- **Los hombres:** Los cortes de cabello seran permitidos solamente por gerente del caso o Administracion
- **Las mujeres:** corte y color de cabello y maquillaje deben ser aprobados (honores solamente) depilarse la ceja (transición) y depilación (Honores) necesita la aprobación del supervisor o del gerente del caso Sin relacion con los estilos de las pandillas
- No productos de tabaco, alcohol o drogas ilicitas
- No puede manejar o operar vehículos de motor (ATV bicicleta de montaña, etc)
- Deportes de alto riesgo deben de ser aprobados por el supervisor o el gerente del caso
- No pueden traer cosas al campamento sin ser aprobadas
- Tiene que llamar todos los días entre las 6 00 am y las 10 00 am, 1 00 pm y las 4 00pm y 6 00pm a las 10 00pm Incluyendo el dia que seas liberado y el dia que regreses al campamento Fracaso de no hablar se resulta en acortamiento de la visita o otras consecuencias adicionales

Por favor recuerde que su hijo/a ha sido puesto en un centro de tratamiento y aunque usted no esté de acuerdo con los reglamentos mencionados arriba y si no los sigue le afectara a su hijo/a. No se desvié de los reglamentos mencionados para que le dé a su hijo/a la oportunidad de obtener confianza. Estas oportunidades vendrán después.
La manipulación de su hijo/a de los reglamentos serán repasados como una violación adicional su intento de bloquear los reglamento serán vistos como una violación y afectara el programa e su hijo/a. Por favor sepa que nosotros tendremos a su hijo/a responsable no importa quien ha sido responsable. Esto incluye pero no es limitado a no regresar al campamento a un tiempo específico.

Firma del Padre

Firma del Residente

Patient Treatment Consent Form

Patient Name: _____

Date of Birth: _____

Purpose of Consent: This consent form provides information about the dental treatment(s) you may receive. The attached treatment plan includes the possible procedures, associated CDT codes, typical UCR (Usual, Customary, and Reasonable) fees based on the ADA guide for Nevada, potential risks, benefits, and alternatives to treatment. All treatment completed will be billed to insurance, and any remaining balances will be paid by our non-profit Sagebrush Smiles 501(c)(3). You will not receive any bills for services completed through our program.

Procedures, CDT Codes, and UCR Fees:

- Exams (D0120/D0150): $50 - $80
- X-rays (D0210/D0272): $30 - $150
- Prophys (D1110/D1120): $75 - $120
- SRP (D4341/D4342): $200 - $300 per quadrant
- D4346 (Scaling in presence of gingival inflammation): $100 - $150
- Varnish (D1206): $30 - $50
- Palliative Fillings (D2940): $100 - $150
- Holding Care (SDF and/or D1355): $50 - $75
- Sealants (D1351): $40 - $60 per tooth
- Fillings (D2391/D2392): $150 - $250
- Extractions (D7140): $100 - $300

Risks of Treatment:

1. Discomfort or pain during and after treatment.
2. Temporary or permanent sensitivity in treated teeth.
3. Potential for complications such as infection, swelling, or bleeding.
4. In rare cases, an allergic reaction to materials used during treatment.

Benefits of Treatment:

1. Relief from dental pain and infection.
2. Improved oral health and prevention of further dental issues.
3. Restoration of teeth function and aesthetics.

Alternatives to Treatment:

1. No treatment (understanding the risks of progression of the condition).
2. Alternative dental procedures (discussed with the provider).
3. Referral to a specialist for advanced care.

Acknowledgment: I have been provided the opportunity to ask questions and discuss my treatment plan with the dentist. I understand the nature of the recommended treatment(s), associated risks, benefits, and alternatives. I understand that the treatment plan may need to be modified during the procedure based on my condition, and I consent to necessary adjustments as determined by the dentist.

Signature Section:

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____

Date: _____

Dentist Name (Print): _____

Dentist Signature: _____

Date: _____

Detailed Informed Consent Form

Patient Name: _____ **Date of Birth:** _____

Date of Exam: _____

Purpose of Consent: This document provides detailed information about the dental treatments proposed as part of your treatment plan. Each treatment is listed below with its corresponding CDT code. This consent form outlines the purpose, benefits, risks, and alternatives for each procedure. You may choose to accept all proposed treatments, refuse all treatments, or refuse specific treatments. The treatments listed on your treatment plan are not tailored to your individual needs.

Proposed Treatments and CDT Codes:

1. **Scaling and Root Planing (SRP) or Scaling in the Presence of Inflammation** - CDT Codes: D4341/D4342/D4346
    - Purpose: Remove plaque, tartar, and bacteria from beneath the gumline to treat gum disease.
    - Benefits: Reduces gum inflammation, halts progression of periodontal disease.
    - Risks: Temporary sensitivity, minor gum irritation, and potential discomfort.
    - Alternatives: Regular prophylaxis (not appropriate for gingivitis/periodontal disease).
2. **Filling** - CDT Codes: D2391/D2392
    - Purpose: Restore decayed or damaged teeth.
    - Benefits: Prevents further decay and restores function and appearance.
    - Risks: Temporary sensitivity, allergic reaction to materials (rare).
    - Alternatives: Extraction (if tooth cannot be restored).
3. **Palliative Filling/Temporary Crown** - CDT Code: D2940/D2799
    - Purpose: Temporary filling to alleviate pain or discomfort.
    - Benefits: Provides interim relief until definitive treatment can be completed.
    - Risks: May dislodge or wear down quickly, requiring further intervention.
    - Alternatives: Permanent filling, permanent crown or extraction.
4. **Indirect Pulp Cap** - CDT Code: D3120
    - Purpose: Protect the dental pulp when decay is close to the nerve.
    - Benefits: Preserves tooth vitality in attempt to avoid root canal treatment.
    - Risks: Possible need for further treatment if pulp becomes infected.
    - Alternatives: Root canal treatment.
5. **Silver Diamine Fluoride (SDF)** - CDT Code: D1354
    - Purpose: Arrest active tooth decay.
    - Benefits: Minimally invasive, reduces decay progression.
    - Risks: Permanent black staining of decayed areas, potential mild gum irritation.
    - Alternatives: Fillings or crowns.

6. **Extractions** - CDT Code: D7140
    - Purpose: Remove severely damaged or decayed teeth.
    - Benefits: Resolves pain and prevents further infection.
    - Risks: Pain, swelling, infection, dry socket (in some cases).
    - Alternatives: Root canal treatment (if tooth is restorable).

Refusal of Treatment:

- I understand that I may refuse all proposed treatments or specific treatments listed above.
- Refusal to accept recommended treatments over time can result in worsening dental and systemic health conditions.

Note on Mandated Reporting: Dentists are mandated reporters under Nevada Revised Statutes (NRS) and must report suspected cases of dental neglect. Repeated refusal of necessary treatments may be considered neglect, which must be reported as required by law.

Acknowledgment and Consent:

I have reviewed the treatment plan and the descriptions of the proposed treatments. I understand the purpose, benefits, risks, and alternatives of the procedures. I have had the opportunity to ask questions and receive answers to my satisfaction.

Signature Section:

Patient Name (Print): _____

Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____

Date: _____

Dentist Name (Print): _____

Dentist Signature: _____

Date: _____

DENTAL DAY CONSENT FORM

Hello! Your child's school/facility has elected to host a Dental Day provided by Sagebrush Smiles. We are a non-profit, founded by Dr. Whitney Bryant DDS. Dr. Bryant founded this non-profit in order to share education, preventative treatment and resources with Northern Nevada. Our hope is to be an oral health advocate for students, parents and schools. We champion the "Oral Health is Health" mindset and hope to increase access to care for oral health in addition to providing treatments and services that can help kids keep their teeth healthy and cavity free.

If you consent, your child will be seen by a licensed professional and may receive a wide variety of services including: intraoral photos (no x-rays), oral health screening, comprehensive oral exam, oral health education, dental sealants, dental cleanings, antibacterial iodine and/or fluoride treatments. THERE IS NO FEE for the child or family. However, we bill Private Insurance/Medicaid and receive funding from local, state, and national partners in the form of grants and donations. This CONSENT FORM MUST BE SIGNED in order for your child to participate. This is confidential information that will be shared with only you and your school/facility nurse. You, nor your school/facility, will ever receive a bill.

Student Name: _____ Date of Birth:_____
Gender: M F Age:_____ Grade:_____ School:_____
Medical History (List Conditions):_____
Medications (List):_____
Allergies: NONE Iodine Latex Penicillin Other:_____
Child's Dental Insurance (Circle one): None Private Insurance **Medicaid#**_____
Private Dental Insurance Carrier:_____ (Ex: Aetna, Delta, Metlife etc)
Private Dental Insurance Subscriber Name: _____ Date of Birth: _____
Member ID:_____ Insurance Phone Number:_____
Last Dental Visit(circle): 0-3 months 3-6 months 6-12 months 12-18 months Never
Does your child have dental anxiety? Yes No Unknown
Please List any procedures you DO NOT want your child to participate in: _____

Parent/Guardian Full Name:_____ Relationship to child:_____
Complete Mailing Address:_____
Phone Number:_____Email:_____

General Participation Consent:.By signing this consent, I am authorizing protected health information as specified below about the patient/child identified on this form to be used by Sagebrush Smiles to capture and share data with the participating provider, internal departments, and with the State of Nevada., as required (1) by law or regulation; (2) to verify eligibility for Medicaid dental benefits and/or to provide information about the same; If applicable, submit for reimbursement to third party payers, such as Medicaid or private insurance(3) to facilitate appropriate follow-up care with a dental provider in keeping with the recommendations made during the screening; (4) case management to ensure that appropriate follow-up care has been received; and/or (5) to protect the patient's health and safety. Upon my request Sagebrush Smiles must provide me with a copy of this form. I understand that signing this form is voluntary. As the legal parent/guardian, I hereby consent to allow my child to participate in a free dental day. I understand that these services do not include x-rays but do include a visual dental exam by a Dental Professional. I understand I will need to sign a second consent form for my child to receive comprehensive care. I release Sagebrush Smiles of liability for adverse outcomes. Consent includes: intraoral photos (no x-rays), oral health screening, comprehensive oral exam, oral health education, dental sealants, dental cleanings, antibacterial iodine and/or fluoride treatments. This consent is valid for ONE year and can be revoked by contacting us.

Signature:_____ Date:_____

DENTAL DAY CONSENT FORM

¡Hola! La escuela de su hijo ha sido elegido para participar en un Día Dental proporcionado por Sagebrush Smiles. Somos una organización sin fines de lucro, fundada por la Dra. Whitney Bryant DDS. El Dr. Bryant fundó esta organización sin fines de lucro con el fin de compartir educación, tratamiento preventivo y recursos con el norte de Nevada. Nuestra esperanza es ser un defensor de la salud oral para los estudiantes, los padres y las escuelas. Defendemos la mentalidad de "La salud oral es salud" y esperamos aumentar el acceso a la atención para la salud oral, además de proporcionar tratamientos y servicios que puedan ayudar a los niños a mantener sus dientes sanos y libres de caries.

Si usted da su consentimiento, su hijo será visto por un profesional con licencia y puede recibir una amplia variedad de servicios que incluyen: fotos intraorales (sin radiografías), exámenes de salud oral, examen oral completo, educación sobre salud oral, selladores dentales, limpiezas dentales, tratamientos antibacterianos con yodo y/o fluoruro. NO HAY NINGUNA TARIFA para el niño o la familia. Sin embargo, facturamos a Medicaid y recibimos fondos de socios locales, estatales y nacionales en forma de subvenciones y donaciones. Este FORMULARIO DE CONSENTIMIENTO DEBE ESTAR FIRMADO para que su hijo pueda participar. Esta es información confidencial que se compartirá solo con usted y la enfermera de su escuela. Ni usted, ni su escuela, recibirán nunca una factura.

Nombre del estudiante: _____ Fecha de nacimiento:_____
Sexo: M F Edad:_____ Escuela:_____
Historial médico (lista de afecciones):_____
Medicamentos (Lista):_____
Alergias: NINGUNA Yodo Látex Penicilina Otros:_____
Seguro dental para niños (marque uno): Medicaid #_____ Seguro Privado Ninguno
Compañía de seguros dentales privados: _____ (por ejemplo: Aetna, Delta, Metlife, etc.)
Última visita al dentista (círculo): 0-3 meses 3-6 meses 6-12 meses 12-18 meses Nunca
¿Su hijo tiene ansiedad dental? Sí No Desconocido
Por favor, enumere cualquier procedimiento en el que NO quiera que participe su hijo: _____

Nombre completo del padre/tutor:_____
Relación con el niño:_____
Dirección para correspondencia:_____
Número de teléfono:_____Email:_____

Consentimiento General de Participación:. Al firmar este consentimiento, autorizo que Sagebrush Smiles utilice la información médica protegida como se especifica a continuación sobre el paciente/niño identificado en este formulario para capturar y compartir datos con el proveedor participante, los departamentos internos y con el estado de Nevada, según lo exija (1) la ley o el reglamento; (2) para verificar la elegibilidad para los beneficios dentales de Medicaid y/o para proporcionar información sobre los mismos; Si corresponde, presentar el reembolso a terceros pagadores, como Medicaid o seguros privados(3) para facilitar una atención de seguimiento adecuada con un proveedor dental de acuerdo con las recomendaciones hechas durante la evaluación; (4) manejo de casos para asegurar que se haya recibido la atención de seguimiento adecuada; y/o (5) para proteger la salud y la seguridad del paciente. A petición mía, Sagebrush Smiles debe proporcionarme una copia de este formulario. Entiendo que la firma de este formulario es voluntaria. Como padre/tutor legal, doy mi consentimiento para permitir que mi hijo participe en un día dental gratuito. Entiendo que estos servicios no incluyen radiografías, pero sí un examen dental visual realizado por un profesional dental. Entiendo que todavía tendré que hacer un seguimiento con un dentista familiar para la atención integral de mi hijo. Libero a Sagebrush Smiles de la responsabilidad por resultados adversos. El consentimiento incluye: fotos intraorales (sin radiografías), exámenes de salud oral, examen oral completo, educación sobre salud oral, selladores dentales, limpiezas dentales, tratamientos antibacterianos con yodo y/o fluoruro. Este consentimiento es válido por UN año y puede ser revocado poniéndose en contacto con la enfermera de su escuela.

Firma:_____
Fecha:_____

Aimee Hennarty, PATH Cert. ESMHL/AAL/AAT

Interactions with Therapy Dog: Informed Consent, Release and Waiver

INTRODUCTION:

RISKS AND BENEFITS:

There are many benefits associated with working with therapy animals. Some benefits that have been found in utilizing therapy animals include:

• Animals help improve motivation and engagement in therapy.

• Animals provide a sense of security and emotional support. Dogs offer unconditional acceptance and positive regard.

• Animals can promote relaxation. Research has demonstrated that petting an animal can help lower blood pressure, heart rate, and increase oxytocin (a feel-good chemical in the brain).

• Animals can help the client learn frustration tolerance and other anger management techniques.

• Animals can help in the areas of focus and attention.

• Animals can be instruments of learning, which can increase self-confidence and self-esteem.

• Animals offer humor and fun due to their playful nature.

• Animals in therapeutic settings ask for clients to develop empathy, nurturance, and responsibility, and model other skills like forgiveness and patience.

Even though there are many benefits to working with therapy animals, there are risks involved in utilizing this method of therapy. For example: dogs may nibble, accidentally scratch, lick, lean up against a client, and/or cause light bruising. These actions are not aggression but rather the dog's way of interacting with the client. In addition, if the client is allergic to dogs or is unaware of an allergy, the client may suffer from an allergic reaction.

ASSESSMENT:

Working with a therapy dog in training may not be appropriate for each client or at every session.

Its use will be determined on a case-by-case basis. In the following circumstances, working with animal will not be used or will cease:1. If the client has a history of animal abuse/cruelty, or there are other risk factors that indicate potential harm to animal.

2. If the client has a known allergy to dogs or an unknown allergy becomes known during client session.

3. If the client exhibits problematic behavior toward animal, including but not limited to: kicking, biting, pushing, hitting, pulling the tail/ears/paws, and/or pinching animal.

4. If the client has a fear of animals and the scope of the client's treatment is not meant to address that fear.

ALLERGIES:

The client shall inform Aimee of any and all known allergies. Animal may be at Aimee's office every day. Although a specific client may not be interacting with animal, animal will still be present in Aimee's care. If the client has an allergy to animal, Aimee will then determine whether any arrangements may be made to accommodate the allergy.

ACCIDENTAL INCIDENTS:

If canine accidentally scratches, nibbles, or otherwise causes any harm to the client, the client agrees to notify Aimee immediately.

INTERACTIONS WITH CANINE:

Dogs interact with humans differently than when humans interact with each other. Dogs wag their tails, lick people, may lean up against a person's leg, or lay near a client. If the client is uneasy or otherwise uncomfortable with how canine interacts with him/her, client agrees to express those concerns immediately to Aimee.

If a client prefers to not engage with canine during sessions, please let Aimee know and she will put canine in its crate.

CONDUCT TOWARD CANINE::

1. Just like a human being, canine should be treated with respect and kindness. If canine is sick or injured, it will not actively be available to work. Canine will obtain veterinary approval prior to resuming work if canine is sick or injured.

2. Aimee is also required to look out for the general welfare and safety of canine. If at any time Canine becomes irritated, frightened, distressed, or in any way exhibits a negative and/or aggressive behavior, canine will take a break. If this occurs, only Aimee may interact with canine until in Aimee's sole and absolute discretion he is able to return to the session.

DISEASE:

Every effort will be made to ensure against zoonotic disease transmission (i.e. the sharing of disease between humans and animals). Canine will remain current on all standard vaccinations,

such as rabies; however, there is always a risk of the transmission of a disease when working with animals. A client may request to review a list of vaccinations canine has.

RELEASE AND WAIVER:

I, _____ hereby agree for myself and/or my minor child to hold China Spring Youth Camp, Aimee Hennarty and their students, volunteers, independent contractors, facility owners, staff and other participants ("Releasees") harmless from any and all claims and/or damages (including medical fees and attorney fees) and causes of action of any nature for any and all personal and/or bodily injury or illness, which may occur to myself or my minor child/ren or which may be aggravated or caused by the negligence of others while interacting with canine.

ASSUMPTION OF RISK: I, _____individually and/or on behalf of any minor child, specifically assume any and all known and unknown risk of injury or illness, resulting from interacting with canine, which may include, but is not limited to: zoonotic disease transmission, scratching, nibbling, heavy leaning, jumping, light brushing, and/or licking by canine, and any unknown or known allergic reaction.

Please indicate if the minor child has any known allergies to dogs: Yes___ No___ Not Sure___

Does the minor child have a known fear of dogs: Yes ___ No ___ Not Sure ___

I agree to abide by Aimee Hennarty's policies and procedures as they specifically relate to canine and its training as a therapy dog. If I have any questions as to conduct that is appropriate when interacting with canine, I agree to ask Aimee before engaging in such conduct.

If any injury and/or illness occurs while engaging with Aimee Hennarty's canine, I, individually and/or on behalf of my minor child, hereby authorize Aimee to contact the medical professional listed below, or if the medical professional is unavailable or cannot be reached, to call 911 or the nearest hospital. I take full responsibility for my welfare and safety as well as for my minor child; and I hereby give permission for emergency medical treatment to be administered as deemed appropriate.

Name, Address and Phone number Information for Medical Professional:

Pinnacle Medical Group
Address: 180 E Winnie Ln, Carson City, NV 89706
Phone: (775) 204-4000

I, individually, and/or on behalf of my minor child, being informed of the above known risks, and acknowledging other potential unknown risks, have read the above waiver, and release. I understand that by signing this Agreement I, individually, and/or on behalf of my minor child am waiving certain legal rights.

Client's Printed Name:

_____

Client/Parent/Legal Guardian Signature:

_____

Date:_____

Douglas County School District
EMPOWER PREPARE INSPIRE CONNECT

Stoddard and Jewel Jacobsen High School
Physical: 225 China Springs Rd.
Gardnerville, Nevada 89410
Mailing: 1638 Mono Ave
Minden, Nevada 89423
Tel: 775-265-5433
Fax: 775-265-6434

Dear Parents:

From time to time Jacobsen High School schedules field trips for their classes. Such trips can be a valuable learning experience and add interest to their subject areas.
In order to avoid a last minute rush of getting parental permission for each field trip, we are asking your approval for your student to go on school sponsored field trips. These trips will always be in camp vehicles and supervised by school personnel and camp staff.

Thank you for your cooperation.

Sincerely,

Gavin Ward
Principal

My child, _____ has ____ does not have ____ my permission to go on school sponsored field trips for the school year 2024-2025.

In the event my child, _____ becomes ill or injured and I cannot be reached, I hereby consent to any diagnostic or medical treatment and hospital services that may be deemed necessary by my family physician, _____, or any physical designated by him/her or the emergency room physician.

_____ _____
Signature of Parent or Guardian Date

_____
Daytime Phone (in case of emergency)

NEVADA DEPARTMENT OF EDUCATION
CODE OF HONOR

There is a clear expectation that all students will perform academic tasks with honor and integrity, with the support of parents, staff, faculty, administration, and the community. The learning process requires students to think, process, organize and create their own ideas. Throughout this process, students gain knowledge, self-respect, and ownership in the work that they do. These qualities provide a solid foundation for life skills, impacting people positively throughout their lives. Cheating and plagiarism violate the fundamental learning process and compromise personal integrity and one's honor. Students demonstrate academic honesty and integrity by not cheating, plagiarizing or using information unethically in any way.

What is cheating?

Cheating or academic dishonesty can take many forms, but always involves the improper taking of information from and/or giving of information to another student, individual, or other source. Examples of cheating can include, but are not limited to:

- Taking or copying answers on an examination or any other assignment from another student or other source
- Giving answers on an examination or any other assignment to another student
- Copying assignments that are turned in as original work
- Collaborating on exams, assignments, papers, and/or projects without specific teacher permission
- Allowing others to do the research or writing for an assigned paper
- Using unauthorized electronic devices
- Falsifying data or lab results, including changing grades electronically

What is plagiarism?

Plagiarism is a common form of cheating or academic dishonesty in the school setting. It is representing another person's works or ideas as your own without giving credit to the proper source and submitting it for any purpose. Examples of plagiarism can include, but are not limited to:

- Submitting someone else's work, such as published sources in part or whole, as your own without giving credit to the source
- Turning in purchased papers or papers from the Internet written by someone else
- Representing another person's artistic or scholarly works such as musical compositions, computer programs, photographs, drawings, or paintings as your own
- Helping others plagiarize by giving them your work

All stakeholders have a responsibility in maintaining academic honesty. Educators must provide the tools and teach the concepts that afford students the knowledge to understand the characteristics of cheating and plagiarism. Parents must support their students in making good decisions relative to completing coursework assignments and taking exams. Students must produce work that is theirs alone, recognizing the importance of thinking for themselves and learning independently, when that is the nature of the assignment. Adhering to the Code of Honor for the purposes of academic honesty promotes an essential skill that goes beyond the school environment. Honesty and integrity are useful and valuable traits impacting one's life.

Student Signature_____ Date: _____

Parent/Legal Guardian Signature_____ Date: _____

Questions or concerns regarding the consequences associated with a violation of the Code of Honor may be directed towards your child's school administration and/or the school district.

Resources: **Cheating policies from Clark and Washoe County School Districts' secondary schools; Foothill Community College**

Revised 8/10

CHINA SPRING YOUTH CENTER
Family questionnaire

Thank you for completing this family questionnaire. Parents or guardians may choose to fill it out together or complete separate copies—whichever works best for you.

Please remember that it's perfectly fine to have differing opinions; what matters most is that your responses are thoughtful, sincere, and honest. Research shows that having a comprehensive understanding of a child's circumstances is crucial for effectively supporting them in making positive changes.

It's also important to note that you don't need to know every detail about your child's behaviors or challenges. Treatment is a journey of discovery rooted in honesty and courage, and this questionnaire serves as a valuable starting point.

While there are several pages, most consist of ample blank space for you to express your thoughts. Don't worry about spelling or grammar—just begin writing!

Please list all family members and/or anyone else in household:

Name	Living in Home?	Sex/Age	Relationship to Client

Youth's Living Arrangements (Check all that apply in the last year)

_____Lives w/both parents
_____Lives w/foster family
_____Lives w/one parent
_____Lives w/other relatives
_____Lives alone
_____Other living arrangements
_____Approved adults/friends
_____Private residence
_____Community residential facility
_____Correction facility
_____Homeless shelter
_____Living in motels/hotels
_____On the street
_____ Often on runaway status
_____Other Institutional setting
_____ Unapproved negative friends

Check the areas of concern with the client:

___Has had encounters w/law
___Hard to control
___Poor academic perform
___Bed wetting
___ Withdrawn
___ Frequent Fighting

___Runs away
___Death of family/friend
___Destruction of objects
___Hurts animals
___ Substance abuse or experimentation
___Poor sleeping/nightmares
___Frequent Lying
___Stealing
___Truancy
___ Assaultive behaviors

List other agencies and treatment programs that you are working with now or in the past:

Name	Date Entered	Completed? Yes / No	Contact Person

SCHOOL

Does the youth have a hard time concentrating or staying on task without constant reminders or consequences? Yes No If yes, explain and give examples:

Does the youth get "picked on" or get victimized a lot by other youth? Yes No

Is the youth the aggressor and picks on other youth? Yes No

Overall, what types of problems does he/she experience in social situations?

Are there any school behavior problems? If so, please explain:

School and school counselor name_____

SUICIDE: Has the youth ever expressed suicidal thoughts or engaged in behaviors that may be considered intentionally self-destructive? Examples of such behaviors include, but are not limited to, self-harm (e.g., cutting), substance overdose, self-asphyxiation, provoking physical harm, reckless driving, or engaging in dangerous activities.

Yes No If yes, explain:

HISTORY OF NEUROLOGICAL PROBLEMS:

Has the youth ever been involved in an accident, fall, sporting activity, car accident, or physical assault where there was a blow to the head? Yes o No o

Did the blow result in loss of consciousness? Yes No

Has the youth lost consciousness due to blood loss, or medical problems? Yes No

How long was the youth unconscious?

Did the youth see a doctor for this incident. Yes No If yes, what was the finding?

Has the youth ever had seizures? Yes o No o

Were these seizures drug or alcohol related? Yes o No o

Has the youth been treated for these seizures? Yes o No o

IMMEDIATE FAMILY HISTORY

Has the youth ever been or currently is a victim of domestic violence? Including sexual assault? Yes o No o If yes, please explain:

Is there a family history of a restraining/no-contact court order? Yes No
If yes, please explain why and for how long:

Biological Father

Has father been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does he have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Biological Mother

Has mother been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does biological mother have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Step Father

Has stepfather been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does he have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Step Mother

Has stepmother been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does she have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Siblings

Has a sibling been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does sibling he/she have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

EXTENDED FAMILY HISTORY OF ADDICTION OR MENTAL ILLNESS:

Long term multi-generational family history is very important to understanding and treating a youth's addictions and mental health needs. Please briefly explain the biological mother's and father's family history of addictions and mental health issues:

1. What mental health or substance abuse issues exist or existed in the mother's side of the family, and for whom?

2. What mental health or substance abuse issues exist or existed in the father's side of the family, and for whom?

Please complete the following form with information about the youth's current medications and recent health appointments.

Current Medications
Please list any current medications the youth is taking:

Medication Name Dosage Frequency Start Date Reason Prescribed
1. _____

2. _____

3. _____

4. _____

Date of last dental appointment: _____

Location of last dental appointment: _____

Date of last vision appointment: _____

Location of last vision appointment: _____

Please ensure all fields are completed accurately. If you have any additional information or concerns regarding the youth's health, please feel free to include them below.

Additional Notes/Comments:

YOUR OPINION AND FEELINGS

Instructions: This is your page to simply summarize your personal opinion and feelings about the youth and your family. Please be honest, and help us to see the bigger picture. This will help us help you.

How does your family get along?

Describe one really good time and one really bad time in your family:

What kind of family problems are you experiencing within the home?

How can this program help you and your family at home?

What else, if anything, should we know about your young person and the family so that we can really help you throughout this process?

Thanks for taking the time to complete this questionnaire, it will really help!

The following consents are for programs/activities offered at various times throughout the year. Your child may or may not be a participant based on scheduling. However, we ask that you please complete the consents to ensure a smooth flow of operations.

Thank you!

CARSON CITY HEALTH & HUMAN SERVICES
900 EAST LONG STREET
CARSON CITY, NEVADA 89706
775-887-2190

POSITIVE YOUTH DEVELOPMENT NEVADA PREP | SRAE

AHEP Adolescent Health Education Programs

For Office Use Only

Session #: _____ Facilitator: _____

Session Dates & Location: _____ Class Age Group: _____

Carson City Health and Human Services
Adolescent Health Education Program's - Making Proud Choices (MPC)
Permission Slip

Please complete with signature and return to the facilitator before the beginning of the program. Unfortunately, if the permission slip has not been turned in, the youth will not be allowed to participate.

Questions? Please Call Class Facilitator: Nathalie Yanez- Montiel (775)283-7292

Youth's Name: _____ Phone: 775 – 265 - 5350

Date of Birth: _____/_____/_____ Age: _____ Sex: _____

Race (circle one): Asian Black White Hispanic
Native American Native Hawaiian/Alaska Native Other

Mailing Address: 225 China Springs Road

City: Gardnerville State: Nevada Zip: 89410 County: Douglas

The Making Proud Choices (MPC) – Comprehensive: Abstinence and Safer Sex Intervention is an evidence-based teen pregnancy prevention program open to youth ages 13-18. As teaching about sexual health is individual to each family, we want you to know what participants are going to be learning about ahead of time. The course equips teens with the knowledge, tools, and skills needed to reduce their risk of sexually transmitted infections (STIs), HIV, and pregnancy by abstaining from sex or using birth control and condoms if they choose to have sex. The program teaches medically accurate information presented in 8 one-hour modules.

The curriculum modules include:

Module 1: Getting to Know You and Steps to Making Your Dreams Come True
Module 2: The Consequences of Sex: HIV Infection
Module 3: Attitudes about Sex, HIV and Condom Use
Module 4: Strategies for Preventing HIV Infection: Stop, Think, and Act
Module 5: The Consequences of Sex: Sexually Transmitted Diseases
Module 6: The Consequences of Sex: Pregnancy
Module 7: Developing Condom Use and Negotiation Skills
Module 8: Enhancing Refusal and Negotiation Skills

The purpose of this program is to inform and empower youth to consider the immediate risks and life-long consequences that are associated with sex. Participants discuss what constitutes sexual responsibility such as choosing to not have sex as the 100% effective way of preventing pregnancy and STIs, as well as using contraceptives and condoms if they choose to have sex. This course includes a definition of oral, vaginal, and anal sex in the context of pregnancy and the transmission of STIs, a display and conversation of different types of birth control and a demonstration of the steps in using condoms correctly. Students will NOT be given condoms or birth control.

Youth are be asked to complete a survey at the beginning and end of the program. Youth will not be asked to put their names or other identifying information on the surveys. The purpose of the survey is to show what participants have learned. The survey asks participants questions about:

- Healthy relationships, saying no to peer pressure, and managing emotions
- Thinking through consequences of having sex
- Goals and plans about graduating high school and college
- Talking to parents and/or guardians about the teens life in general and having sex
- Their opinion about elements of the course

I (your name), _____, as the parent or legal guardian of (youth's name)_____, understand the subject matter that will be taught in this program and give my consent for this youth to participate in the Promoting Health Among Teens – Abstinence Only Intervention program. I understand that the program incentive, if applicable is to be given to the youth named on this form.

Signature: _____ Date: _____

Return the permission slip before the start date of the class to: nyanez@carsoncity.gov

Or by mail:

Carson City Health and Human Services
AHEP – Nathalie Yanez- Montiel
900 E. Long Street
Carson City, NV 89706

Or by Fax:

Attn: Nathalie Yanez- Montiel
Fax #: (775) 887-2248

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EAST FORK SWIMMING POOL DISTRICT
Carson Valley Swim Center
Waiver of Liability

By my signature below, I acknowledge that I am aware of, understand the character of, and voluntarily assume the risks involved in participating in all activities associated with swimming and other activities available at the Carson Valley Swim Center.

By my signature below, on behalf of myself, my heirs, next of kin, successors in interest, assigns, personal representatives, and agents, I hereby:

1. Waive any claim or cause of action against and release from liability the East Fork Swimming Pool District and the Carson Valley Swim Center, its officers, employees, and agents for any liability for injuries to my person or property resulting from my use of the facility or participation in any of the activities listed above;

2. Agree to indemnify and hold harmless the East Fork Swimming Pool District and the Carson Valley Swim Center, its officers, employees, and agents for any claims, causes of action or liability to any other person arising from my use of the facilities or participation in the activities listed above;

3. Consent to receive any medical treatment deemed advisable in the event of injury, accident or illness during these activities; and

4. Acknowledge that if a participant under 18 years of age is to be the participant, the parent or legal guardian of the minor child must sign this Waiver of Liability.

I HAVE READ THIS ASSUMPTION OF RISK, WAIVER OF LIABILITY AND RELEASE AGREEMENT. I CONSENT TO MEDICAL TREATMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE, OR GUARANTEE BEING MADE TO ME AND INTEND MY SIGNATURE TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW.

Participant Printed Name _____ Date of Birth _____

Signature _____ Date _____

Address _____ City _____ State _____

Minors (under 18 years of age):

Parent/Legal Guardian Printed Name _____ Relationship _____

Parent or Legal Guardian Signature _____ Date _____

Rock Wall Climbing Assumption of Risk, Release of Liability, and Indemnification Agreement

DOUGLAS COUNTY
PARKS & RECREATION DEPARTMENT

Adult climber or Guardian's Last Name: _____ **First Name:** _____

Minor Climber's Last Name if any : _____ **First Name (s)** _____

Address: _____

City _____ **State** _____ **Zip** _____

Phone: _____ **Male/Female** _____ **Date of Birth/s** _____

Emergency Contact: _____ **Phone:** _____

Medications taken by climber/climbers : _____

Allergies: _____

NOTICE: THIS IS A LEGALLY BINDING AGREEMENT AND BY SIGNING IT YOU GIVE UP YOUR RIGHT TO FILE A LAWSUIT, RECOVER COMPENSATION, OR OBTAIN ANY OTHER REMEDY AGAINST DOUGLAS COUNTY IF YOU ARE INJURED USING THE ROCK CLIMBING WALL AT THE DOUGLAS COUNTY COMMUNITY AND SENIOR CENTER. PLEASE READ CAREFULLY.

I have voluntarily chosen to participate in rock wall climbing at the Douglas County Community and Senior Center. I am aware that rock wall climbing is inherently dangerous, and may result in serious injury or death. My participation in rock wall climbing is undertaken with full knowledge of the risks and dangers involved, which include, but are not limited to:

- Falls, fractures, paralysis, concussions, overexertion, overheating, injuries from my lack of fitness or conditioning, communicable diseases, and exposure to allergens which could cause allergic reactions;

- Rope abrasion, entanglement or other injuries resulting from rock wall climbing activities such as climbing, belaying, rappelling, lowering on rope, rescue systems, or any other climbing/rope techniques;
- Injuries resulting from the negligence of others, falling climbers, or dropping items such as ropes and climbing hardware;
- Cuts and abrasions resulting from skin contact with the rock climbing wall and related equipment;
- Failure of equipment including, ropes, slings, harnesses, climbing hardware, anchor points, or any other part of the climbing wall structure.

I further acknowledge that the above list does not include all possible risks of rock wall climbing, and that the above list in no way limits the application of this agreement.

In consideration of my use of the Rock Climbing Wall at the Douglas County Community and Senior Center, and with full knowledge of all related risks, I hereby agree as follows:

1. **ASSUMPTION OF THE RISK(S):** I hereby freely assume the inherent risks and all other risks related to rock wall climbing, and any harm, injury, illness, or loss that may occur to me or my property as a result of my participation in rock wall climbing, including any harm, injury, or loss caused by the negligence of Douglas County, its employees, agents, officers, volunteers, and contractors, and any other rock wall climbing participants. I also understand that any equipment that I provide or may borrow from Douglas County or others I use at my own risk and that any such equipment is provided without any warranty about its condition or suitability.

2. **RELEASE OF LIABILITY.** I, on behalf of myself, my heirs, representatives, executors, administrators, and assigns, do hereby release Douglas County, its employees, agents, officers, elected officials, volunteers, and contractors from any cause of action, claim, liability, or demand of any nature whatsoever, including but not limited to, a claim of negligence which I, my heirs, representatives, executors, administrators, and assigns may now have, or have in the future against Douglas County on account of personal injury of any kind, property damage of any kind, death, or accident of any kind, arising out of or in any way related to my use of the rock climbing wall. I understand that I will be solely responsible for any injury, loss, or damage, including death, that I sustain relating to my use of the rock wall, and that by this agreement, I relieve Douglas County of any and all liability for such injury, loss, or damage, including death.

3. **INDEMNIFICATION, HOLD HARMLESS, AND DUTY TO DEFEND.** I hereby promise to indemnify, hold harmless, and defend Douglas County, its employees, agents, officers, elected officials, volunteers, and contractors, from any cause of action, claim, liability, or demand of any nature whatsoever, including but not limited to, a claim of negligence arising out of or in any way related to my use of the rock climbing wall. I also promise to

indemnify, hold harmless, and defend Douglas County from any and all claims relating to my own negligence, and any other claim arising out of my use of the rock climbing wall.

4. **AGREEMENT TO FOLLOW ALL ROCK CLIMBING WALL RULES.** I hereby agree to follow all rock climbing wall rules provided by Douglas County.

5. **SEVERABILITY.** I agree that this agreement shall operate as an Assumption of the Risk, Release of Liability, and Indemnification agreement as broad and inclusive as allowable under Nevada law. I agree that if any portion or provision of this agreement is found to be invalid or unenforceable by a court of law, then the remaining portion or provisions will continue in full force and effect.

6. **APPLICABLE LAW AND FORUM.** This Agreement shall be interpreted and construed in accordance with the laws of the State of Nevada, without any reference to choice of law rules. I agree that any dispute arising from or related to this Agreement, or in any way associated with my use of the rock climbing wall shall be brought only in the 9th Judicial District Court for the State of Nevada., and I agree and consent to the exclusive jurisdiction and venue of the court for any such dispute.

I HAVE FULLY INFORMED MYSELF OF THE CONTENTS OF THIS AGREEMENT BY READING IT BEFORE SIGNING IT. NO ORAL REPRESENTATIONS, STATEMENTS OR OTHER INDUCEMENTS TO SIGN THIS AGREEMENT HAVE BEEN MADE APART FROM WHAT IS CONTAINED IN THE WRITTEN AGREEMENT. I UNDERSTAND THIS IS A CONTRACT THAT AFFECTS MY LEGAL RIGHTS AND I SIGN IT VOLUNTARILY.

Signature of Rock Wall User: _____
Printed Name: _____
Date: _____

IF ROCK WALL USER IS A MINOR, SIGNATURE OF A PARENT OR RESPONSIBLE ADULT IS REQUIRED BELOW

In consideration of the minor child being permitted to use the rock climbing wall, I accept and agree to the full contents of this Agreement. I certify that I have full authority to sign this Agreement on behalf of the minor child, and intend to bind the minor child and myself to all Agreement terms.

Parent/Responsible Adult Signature: _____
Relationship to Minor: _____
Printed Name: _____
Date: _____

NRS 62B.510 Rights of child placed in detention facility.

Except as otherwise provided in NRS 62B.520, a child who is placed in the care and custody of a detention facility within this State has the right:

1. To receive information concerning his or her rights set forth in this title.

2. To be treated with basic human dignity and respect, without intentional infliction of humiliation.

3. To have fair and equal access to services, placement, care, treatment and benefits.

4. To a program of education that meets the requirements of law and is appropriate for the developmental maturity of the child.

5. To receive adequate, healthy and appropriate food.

6. To receive adequate, appropriate and accessible basic necessities, including, without limitation, shelter, clean clothing and personal hygiene products and facilities.

7. To have access to necessary medical and behavioral health care services, including, without limitation:

(a) Dental, vision and mental health services;

(b) Medical and psychological screening, assessment and testing; and

(c) Referral to and receipt of medical, emotional, psychological or psychiatric evaluation and treatment as soon as practicable after the need for such services has been identified.

8. To be free from:

(a) Abuse or neglect, as defined in NRS 432B.020.

(b) Corporal punishment, as defined in NRS 388.478, except the reasonable use of force that is necessary to preserve the order, security or safety of the child, the public, the staff of the detention facility or other children who are detained in the detention facility.

(c) The administration of psychotropic medication unless the administration is consistent with the policies established pursuant to NRS 62B.530.

(d) Discrimination or harassment on the basis of his or her actual or perceived race, ethnicity, ancestry, national origin, color, religion, sex, sexual orientation, gender identity or expression, mental or physical disability or exposure to any communicable disease.

(e) The deprivation of food, sleep, exercise, education, pillows, blankets or personal hygiene products as a form of punishment or discipline.

(f) Being searched for the purpose of harassment or as a form of punishment or discipline.

(g) Being restricted from a daily shower, clean clothing, drinking water, a toilet or reading materials relating to the education or detention of the child as a form of punishment or discipline.

9. To have reasonable access and accommodations to participate in religious services of his or her choice when reasonably available on the premises of the detention facility or to refuse to participate in religious services.

10. To communicate with other persons, including, without limitation, the right:

(a) To have regular contact through visits, telephone calls and mail with:

(1) Biological children;

(2) Parents;

(3) Guardians;

(4) Attorneys; and

(5) Other adults with whom the child has established a familial or mentoring relationship, including, without limitation, clergy, caseworkers, teachers, mentors and other persons, upon approval of the detention facility.

(b) To communicate confidentially with:

(1) Any agency which provides child welfare services to the child concerning his or her care;

(2) Attorneys, legal services organizations and their employees and staff;

(3) Ombudspersons and other advocates;

(4) Members of the clergy; and

(5) Holders of public office, and people who work at a state or federal court.

➥ Except as otherwise provided by specific statute, a communication made pursuant to this paragraph is not a privileged communication.

(c) To report any alleged violation of his or her rights pursuant to NRS 62B.525 without being threatened or punished.

11. To participate, in person, by telephone or by videoconference, in all court hearings pertaining to the circumstances which led to the detention of the child.

(Added to NRS by 2017, 744)

NRS 62B.515 Duty of detention facility to provide notice and copies and post written copy of rights. A detention facility shall:

1. Inform the child of his or her rights as set forth in NRS 62B.510;

2. Provide the child with a written copy of those rights;

3. Provide an additional written copy of those rights to the child upon request;

4. To the extent that it is practicable, provide a written copy of those rights to the parent or guardian of the child; and

5. Post a written copy of the rights set forth in NRS 62B.510 in a conspicuous place inside the detention facility.

(Added to NRS by 2017, 746)

NRS 62B.520 Reasonable restrictions on exercise of rights by child. A detention facility may impose reasonable restrictions on the time, place and manner in which a child may exercise his or her rights set forth in NRS 62B.510 if such restrictions are necessary to preserve the order, security or safety of the child, the public, the staff of the detention facility or other children who are detained in the detention facility.

(Added to NRS by 2017, 746)

NRS 62B.525 Authorized manner for child in detention facility to raise and redress a grievance.

If a child believes that any of his or her rights set forth in NRS 62B.510 have been violated, the child may raise and redress a grievance through, without limitation:

1. A member of the staff of the detention facility;

2. A probation officer or parole officer;

3. An agency which provides child welfare services to the child, and any employee thereof;

4. A juvenile court with jurisdiction over the child;

5. A guardian ad litem for the child;

6. An attorney for the child; or

7. The use of any appropriate procedure which has been established by the Division of Child and Family Services to address grievances for children, both in and out of detention

NRS 62B.530 Detention facilities to establish policies concerning accessibility, administration and concurrent use of psychotropic medication for children.

Each detention facility shall establish appropriate policies to ensure that children who are detained in the detention facility have timely access to and safe administration of clinically appropriate psychotropic medication. The policies must include, without limitation, policies concerning:

1. The use of psychotropic medication in a manner that has not been tested or approved by the United States Food and Drug Administration, including, without limitation, the use of such medication for a child who is of an age that has not been tested or approved or who has a condition for which the use of the medication has not been tested or approved;

2. The concurrent use by a child of three or more classes of psychotropic medication; and

3. The concurrent use by a child of two psychotropic medications of the same class.

NRS 432B.020 "Abuse or neglect of a child" defined.

1. "Abuse or neglect of a child" means, except as otherwise provided in subsection 2:

(a) Physical or mental injury of a nonaccidental nature;

(b) Sexual abuse or sexual exploitation; or

(c) Negligent treatment or maltreatment as set forth in NRS 432B.140,

➥ of a child caused or allowed by a person responsible for the welfare of the child under circumstances which indicate that the child's health or welfare is harmed or threatened with harm.

2. A child is not abused or neglected, nor is the health or welfare of the child harmed or threatened for the sole reason that:

(a) The parent of the child delivers the child to a provider of emergency services pursuant to NRS 432B.630, if the parent complies with the requirements of paragraph (a) of subsection 3 of that section; or

(b) The parent or guardian of the child, in good faith, selects and depends upon nonmedical remedial treatment for such child, if such treatment is recognized and permitted under the laws of this State in lieu of medical treatment. This paragraph does not limit the court in ensuring that a child receive a medical examination and treatment pursuant to NRS 62E.280.

3. As used in this section, "allow" means to do nothing to prevent or stop the abuse or neglect of a child in circumstances where the person knows or has reason to know that a child is abused or neglected.

(Added to NRS by 1985, 1368; A 2001, 1255; 2003, 1149)

NRS 388.478 "Corporal punishment" defined.

"Corporal punishment" means the intentional infliction of physical pain, including, without limitation, hitting, pinching or striking.

(Added to NRS by 1999, 3237)—(Substituted in revision for NRS 388.5225)

NRS 62B.525 Authorized manner for child in detention facility to raise and redress a grievance.

If a child believes that any of his or her rights set forth in NRS 62B.510 have been violated, the child may raise and redress a grievance through, without limitation:

1. A member of the staff of the detention facility;

2. A probation officer or parole officer;

3. An agency which provides child welfare services to the child, and any employee thereof;

4. A juvenile court with jurisdiction over the child;

5. A guardian ad litem for the child;

6. An attorney for the child; or

7. The use of any appropriate procedure which has been established by the Division of Child and Family Services to address grievances for children, both in and out of detention.

(Added to NRS by 2017, 746)