OVER 18
HIPPA AND MEDICAL INFORMATION SHEET

NAME:_____**TROOP#:**_____
(FIRST) (LAST)

OVER18 MEDICAL RECORDS
AUTHORIZATION/PERMISSION HIPAA FORM

I Give permission for Camp Alexander Pikes Peak Council Medical and Management Staff to share my medical information with any Doctor, medical facility/hospital deemed necessary in case of illness or injury. This information will be used for medical treatment and will not be given to anyone other than proper medical personnel.

I also give permission for Camp Alexander Pikes Peak Council Medical and Management Staff to have knowledge of the medications that I take. This information will be used only for the time period that I am Staff or a Volunteer at Camp Alexander.

THIS INFORMATION AND PERMISSION IS GIVEN IN KEEPING WITH CURRENT HIPAA FEDERAL REGULATIONS AND WILL BE KEPT IN ACCORDANCE WITH THE PIKES PEAK COUNCIL BSA RISK MANAGEMENT GUIDELINES.

NAME:_____TROOP NUMBER:_____
(PRINT)
SIGNATURE:_____DATE:_____

EMERGENCY CONTACT INFORMATION

NAME:_____PHONE # (HOME)_____(CELL)_____(WORK)_____
(FIRST) (LAST)
ADDRESS:_____RELATIONSHIP:_____
(STREET) (CITY) (STATE) (ZIP)

SECONDARY EMERGENCY CONTACT INFORMATION

NAME:_____ _____PHONE # (HOME(_____(CELL)_____(WORK)_____
(FIRST) (LAST)
ADDRESS:_____RELATIONSHIP:_____
(STREET) (CITY) (STATE) (ZIP)

DOCTORS INFORMATION

DOCTORS NAME;_____**HOME PHONE:**_____**WORK PHONE:**_____
(FIRST) (LAST)
ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

THIS FORM TO BE ATTACHED TO THE ADULTS CLASS III MEDICAL FORM