

PERMISSION, HIPPA AND MEDICAL INFORMATION SHEET

NAME: _____ TROOP#: _____

(FIRST)

(LAST)

**MEDICAL TREATMENT PERMISSION & MEDICAL RECORDS
AUTHORIZATION/PERMISSION HIPAA FORM**

I _____ as parent or guardian of _____ give permission for my son/daughter to attend Camp Alexander from _____ to _____, I also give permission for Medical treatment to be given to my son or daughter in event of illness or injury. I give Pikes Peak Council Medical and Management Staff permission to share my son or daughters 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 the adult leaders of (**CIRCLE ONE**) Troop/Crew/Team # _____ to have knowledge of any medication that my son or daughter may be taking. This information will be used only for the time period that the above is in the care of the adult leaders.

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

NAME: _____ RELATIONSHIP: _____
(PRINT)

SIGNATURE: _____ DATE: _____

PARENTS EMERGENCY INFORMATION

PARENTS/GUARDIAN'S NAME: _____ HOME PHONE: _____ CELL PHONE _____
(FIRST) (LAST)

ADDRESS: _____ RELATIONSHIP: _____
(STREET) (CITY) (STATE) (ZIP)

PLACE OF EMPLOYMENT: _____ PHONE: _____ ext _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

PARENTS/GUARDIAN'S NAME: _____ HOME PHONE _____ CELL PHONE _____
(FIRST) (LAST)

ADDRESS: _____ RELATIONSHIP: _____
(STREET) (CITY) (STATE) (ZIP)

PLACE OF EMPLOYMENT: _____ PHONE: _____ ext _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

SECONDARY EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ 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 SCOUTS CLASS III MEDICAL FORM