# 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