CAMP ALEXANDER **UNDER 18** PIKES PEAK COUNCIL, BSA

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

CA/HIPAA PERMISSION FORM/06/CAMPER