

**CAMPER UNDER 18 MEDICAL RECORDS
AUTHORIZATION/PERMISSION HIPAA FORM**

I _____ as parent or guardian of _____ give permission for Camp Alexander Pikes Peak Council Medical and Management Staff 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 troop # _____ to have knowledge of the medication that my son or daughter takes. 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: _____

**THIS FORM TO BE ATTACHED TO THE SCOUTS CLASS III MEDICAL FORM
CA/HIPAA PERMISSION FORM/05/CAMPER**

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