Health History and HIPAA

Campers Name

_____

Name of Health Insurance Company

_____

Health Insurance Policy Number

_____

Phone Number

_____

Allergies

_____

_____

Is your child affected by any of the following?

□ ADHD □ Asthma □ Convulsions
□ Diabetes □ Hypertension □ Seizures
□ Bleeding/Clotting Disorder
□ Frequent Ear Infections
□ Heart Defect Disease □ Other
List Other

_____

Is your child currently taking medication?

□ Yes □ No

Name of Medication:_____

Parent/Guardian Signature (required)

_____

Parent/Guardian Printed name (required)

_____

____

Phone number for Parent or guardian

_____

Are there any other concerns that our staff should know about that would help enhance your child's camp experience?_____

_____

Due to outdoor activities sunscreen and possibly bug spray will be applied hourly. By signing below you are stating that you are fine with the application and you will provide sunscreen for your child.

_____

GREAT FALLS
COMMUNITY RECREATION CENTER
HIPAA PRIVACY AUTHORIZATION FORM

I, by signing this Authorization Form, hereby attest that I am a parent or legal guardian of _____ (print child's name) and that I have a legal right to make health care decisions on said child's behalf.

I hereby authorize Great Falls Community Recreation Center to use and disclose any and all protected health information required for the medical treatment of said child. I further authorize that Great Falls Community Recreation Center may release the information to any other organization or person for said medical treatment. This authorization will expire six months after the date below, unless otherwise indicated. (This authorization expires on

_____

I understand that I may revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

Date: _____

Parent or Legal Guardian's Name (Please Print):

_____

Parent or Legal Guardian's Signature:

_____