Name___________________

2011-2012
PARENTAL PERMISSION FOR OFFSITE YOUTH ACTIVITIES/ HEALTH AUTHORIZATION PACKET
for 9th through 12th Graders

Parental Permission for Offsite Youth Activities

"I, __________________________ am the parent or legal guardian of ____________________
(Name of Parent or Legal Guardian) *(Name of Minor)*

and hereby give my permission for him/her to attend all offsite activities sponsored by the First Church of Christ Simsbury Youth Group between August 15, 2011 and August 15, 2012. These events will be supervised by Rev. Kevin Weikel, Associate Minister for Youth and Young Adults, and/or appointed adult leaders of the Youth Groups."

______________________ ________________________________
Date Signature of Parent or Legal Guardian

____
(Contact Name and Phone Number)

AUTHORIZATION FOR MEDICAL TREATMENT

I, ____________________, am the parent or legal guardian of ____________________,
(Name of Parent or Legal Guardian) *(Name of Minor)*
hereinafter "my child", who was born on ___________________, _________. My child is attending and participating in activities at First Church of Christ, Simsbury, Connecticut 06070.

I hereby authorize Rev. Kevin Weikel and his officers, agents, servants, or employees who are 18 years of age or older, who supervise the activities at the youth groups at First Church of Christ, Simsbury (sometimes referred to herein as the "accompanying staff from First Church of Christ, Simsbury") into whose care my child has been entrusted, to consent to emergency medical care or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under state law for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under state law for my child. I further authorize Rev. Kevin Weikel and his/her officers, agents, servants, or employees who are 18 years of age or older, who supervise the activities of the youth groups at First Church of Christ, Simsbury to receive physical custody of my child upon completion of any emergency treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to Rev. Kevin Weikel and his officers, agents, servants, or employees who are 18 years of age or older who supervise the activities at the First Church of Christ, Simsbury.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise of his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and surgeon.

In the event that my child requires emergency medical treatment, I further authorize any EMT or emergency room personnel providing medical treatment to my child to release medical information about my child, including, if applicable, protected drug and/or alcohol abuse, confidential HIV-related, and psychiatric information ("Protected Health Information") to accompanying staff from the First Church of Christ, Simsbury in accordance with the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"). Protected Health Information may include clinical treatment notes, lab results, and any medical recommendations.

Subject to the statements printed below, I hereby authorize the accompanying staff from First Church of Christ, Simsbury to be present during any EMT or ER interventions and hereby permit the on-site exchange of Protected Health Information necessary for my child's immediate medical treatment.

Any Protected Health Information released to the accompanying staff from First Church of Christ, Simsbury during an emergency situation will be treated as confidential information protected from further disclosure in accordance with provisions of federal and state law.

____
(Contact Name and Phone Number)

PSYCHIATRIC INFORMATION

In the event that information released constitutes confidential psychiatric information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE INFORMATION

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV-RELATED INFORMATION

In the event that information released constitutes confidential HIV-related information protected under Connecticut law:

This information has been disclosed to you from records who confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

________________________ ____

Date Signature of Parent or Legal Guardian

____

(Contact Name and Phone Number)

ADDITIONAL INFORMATION

____
Parent / Guardian

____________________ ________________ _________ ________
Address City State Zip

________________ _________________ ___________________
Home Phone Cell Phone Work Phone
(Please circle best phone to use)

____
Email address

___________________________ _______________________________
Medical/Health Insurance Company Insurance Policy No.

____________________________ _______________________________
In Case of Emergency, Notify Relationship to Minor
Parent or Guardian

____
Allergies/Allergic Reaction of My Child

____
Medicine Being Taken by My Child

____
Other Information Regarding My Child's Health that a Doctor Should Know

____
(Contact Name and Phone Number)