# Youth Medical Treatment Release Form

**This form must be completed and received before your child may participate in camp.**

Thank you for registering your child for Summer Day Camp. To ensure your child's safety, Binder Park Zoo requires parents and guardians of campers to grant authority to secure emergency medical treatment. Please know that Binder Park Zoo views this permission with circumspection; our procedures will always include notification and consultation with parents and guardians.

**Camper Name:** _____

**Emergency Contacts:**

Mother's name: _____ Work Phone: (___) _____

Father's name: _____ Work Phone: (___) _____

Other Contact-Name: _____

Relation: _____ Phone: (_____) _____

Doctor's name: _____ Phone: (_____) _____

**Insurance Information:**

Company Name: _____

Name of policyholder: _____

Relationship to Patient: _____

Policy #:

Group #:

**Allergies:**

Foods: _____

Medicines: _____

Animals: _____

Other: _____

**Pre-existing Conditions:**

Medical diagnoses (including psychiatric, psychological and/or mental health): _____

_____

Medications being sent to camp (Epi-pen, OTC, etc.): _____

Instructions for use: _____

Limitation of Camper Activities: _____

*For new campers please provide a hard copy of Immunization records by June 14, 2021*
*7400 Division Drive – Battle Creek, MI 49014 – Fax: 269-979-8834 – or email to awesner@binderparkzoo.org*

**Vaccines required for participation in Summer Day Camps:**

- Hepatitis B; Measles, Mumps, Rubella (MMR); Polio; Tetanus, Diphtheria, Pertussis (Td/Tdap)
- If you do not have proof of vaccination due to a medical or religious reason, please instead provide a letter from the State of Michigan verifying your decision.
- We reserve the right to decline registration based on a camper's vaccine history in order to provide a safe environment for all campers.

By signing, I authorize the staff of Binder Park Zoo to secure emergency medical and surgical treatment, and to provide routine, non-surgical medical, psychological or psychiatric care, for my child while participating in youth camp. Except as set forth above under 'Allergies and Pre-Existing Conditions', I certify that my child is in good health and can participate in all normal activities of the group. I agree to be solely responsible for all expenses incurred for any medical services rendered.
I consent to the HIPAA Disclosure Statement on the reverse side of this form for the participant who is also referred as Patient.

_____ _____

Signature of parent or guardian Date

# Authorization for Disclosure and Use of Protected Health Information

I. I give this Authorization for Disclosure and Use of Protected Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d, and regulations promulgated under HIPAA. It is the Patient's intent that this document is a valid authorization under 45 CFR Part 164, Subpart E (the "HIPAA Privacy Regulations").

II. The Patient authorizes any Covered Entity to disclose any and all of the Patient's Protected Health Information to any Authorized Recipient at the request of such Authorized Recipient, for any purpose or use designated by any Authorized Recipient, including, without limitation, for any purpose. The Patient authorizes any Authorized Recipient to use and disclose any of the Patient's Protected Health Information for any purpose.

III. The Patient has the right to revoke this Authorization at any time. The Patient revokes this Authorization by executing a written revocation of this Authorization. If this Authorization is revoked, then any person acting in good faith reliance on this Authorization, without actual knowledge of the revocation, is held harmless.

IV. The Patient acknowledges that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient, and no longer be protected by the HIPAA Privacy Rule. The Patient acknowledges that, unless provided otherwise in a notice complying with the HIPAA Privacy Regulations under conditions described in the HIPAA Privacy Regulations, a Covered Entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the Patient signs this Authorization. The Patient acknowledges that the Patient has received a copy of this Authorization.

V. This Authorization expires on the earlier of (i) the date that the Patient designates as the expiration date in any written revocation of this Authorization; and (ii) the date which is twenty years after the date of the Patient's death.

VI. All persons may rely on reproduced executed copies of this document. Persons to whom a copy of this document has been provided, including, without limitation, medical care providers, advisors, legal counsel, and family members, may provide a copy of this document to such other persons as any of them, in their discretion, deem appropriate, and I hold such providers harmless and indemnify them from any liability for providing copies of this document.