Youth Medical Treatment Release Form

Thank you for registering your child for our Zoo Teen program. To ensure safety; Binder Park Zoo requires parents and guardians of participants to grant authority to secure emergency medical treatment. Please know that Binder Park Zoo views this permission with circumspection; our procedures will continue to include notification and consultation with parents/guardians.

Participant's Name: ____________________ Birth date: ________ Age: _______ Ht: ________ Wt: ________
Address: ____________________________________ City: ___________________ State: _______ Zip: ________
Home Phone #: ( ) ________________________ Work Phone # (mother): ( ) ________________________
Work Phone # (father): ( ) __________________ Cell Phone #: ( ) ________________________________
Other Emergency Contact-Name: ___________________________ Phone #: ( ) ________________________
Insurance Company Name: ____
Name of policyholder: ________________________ Relationship to Patient: _____________________________
Name of Employer: ____
Policy #: ____________________________ Group #: ____
Doctor's Name and phone #

This Should Be Completed So That It Is Absolutely Accurate

Please submit a copy of immunization history for the participant at the program orientation.

Previous Illnesses	**(AGE)**	**Contagious Disease Protection**	**(YEAR)**
Measles	_______	Measles Immunization	_______
Mumps	_______	Smallpox Immunization	_______
Chicken Pox	_______	Diphtheria Immunization	_______
Scarlet Fever	_______	Whooping Cough Immunization	_______
German Measles	_______	Polio	_______
Rheumatic Fever	_______	Tetanus	_______
Whooping Cough	_______		
Other			

Allergies and Pre-existing Conditions:

Food: ____ Other: ____________________________________

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

____

Medications being sent with Participant (Epi-pen, OTC, etc.): ____

Limitation of Participant Activities: ____

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 a Binder Park Zoo program. 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

7400 Division Drive—Battle Creek, MI 49014—Tel: 269-979-1351—Fax: 269-979-8834—www.binderparkzoo.org

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.