

St. John's Parish Permission Form and Release Statement

I hereby give permission for _____ to attend St. John's Parish activities, events, and retreats, and participate in its activities for the period September 1, 2006 through August 31, 2007. I also give my permission for St. John's staff and volunteer leaders to administer routine first aid (e.g. ibuprofen [e.g. Advil], acetaminophen [e.g. Tylenol], calcium bicarbonate [e.g. Tums], bandage strips, cough medicine [e.g. Robitussin], cortisone cream, antibiotic cream, diphenhydramine hydrochloride [e.g. Benadryl]), obtain emergency medical treatment to be administered to my child, and for medical treatment decisions to be made by the leaders/staff. I understand that an attempt will be made to contact me in the event of an emergency. I hold harmless St. John's Parish and the Episcopal Diocese of South Carolina and the staff and leaders involved in church sponsored activities.

Videotaping and Still Photographs

I authorize St. John's Parish to use photographs and videos of my child for productions, publications, etc. which are exclusively for the purpose of promoting activities related to St. John's Parish.

Guardian Name (print) _____ Date _____

Guardian Signature: _____

Day Phone _____ Mobile Phone _____

Alternate Emergency Contact _____

Relation _____ Phone _____

Medical Insurance Company _____

Id/Group Number _____ Insurance Co. Phone # _____

Allergies (food, medicines, materials such as latex): _____

Please list any medications the student is taking and what they are treating:

_____ for _____

_____ for _____

_____ for _____

Personal Doctor _____ Doctor's Number _____

Other information _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Participant's Name: _____ Date of Birth: _____

Address : _____

Phone: (home) _____ (alternate) _____

The purpose of this disclosure is to facilitate the treatment of the participant in the event of a medical emergency while participating in a St. Johns Parish sponsored activity for the period September 1, 2006 through August 31, 2007.

The type of information to be disclosed is as follows:

problem list	medications	physician progress/visit notes
radiological reports	nurse notes	physician orders
films/images	laboratory results	discharge summary

I understand this information may include reference to physical and psychiatric care.

I authorize the exchange of this information via phone, email, fax, or face to face.

I understand that I have a right to cancel/revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing and present my written cancellation/revocation to St. Johns Parish. I understand that the cancellation/revocation will not apply to information which has already been released in response to this authorization. This authorization will expire when the participant is in my physical custody.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this authorization in order for the participant to receive treatment. I understand that I may review and/or copy the information disclosed. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/ organization receiving the information. If I have questions about the disclosure or use of this participant's protected health information I may contact St. Johns Parish at 559-9560.

I understand that I will be given a copy of this authorization upon request.

Signature of Participant or Legal Guardian

Date: _____

Printed Name of Participant or Legal Guardian

Relationship to Participant if Signed by Legal Guardian

Witness Signature

Description of Participant's Representative's authority (Why participant is not signing): Participant is a minor.