Oklahoma Conference
2024 -2025 Pathfinder Registration Form
Permission/Health Record

Name_____ DOB_____
Club Name _____
Date of last Tetanus Booster_____
Allergies to drugs or food_____
_____
Other Health Information_____
_____
Father's Name _____Cell #_____Work #_____
Mother's Name _____Cell #_____Work #_____
Alternative Emergency contact_____ Cell #_____
E-mail_____
Address_____
Family Physician Name_____ Phone #_____
Address_____
Insurance info. _____

I, the undersigned parent or legal guardian of _____, a minor, do herby consent to any treatment or medical care deemed reasonably necessary. Also, if deemed necessary, I grant permission for hospitalization. I request that any treatment or medical care deemed reasonably necessary be rendered to the above named minor under the general or specific instructions of _____(*name of family physician*), or any physician the organization specified in the following paragraph may call, whether such diagnosis or treatment is rendered at the office of said physician listed above before any other physician is called by the organization. It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize _____ (*Pathfinder leader*) to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect for one (1) year after signing unless revoked in writing and delivered to the physician caring for my minor child and/or to the leader of the organization named above entrusted with the custody of my minor child prior to the end of that one (1) year.

_____ _____
Parent or legal guardian (*underline which*) Date

Authorization for Disclosure of Protected health Information

1. Health information to be obtained or disclosed includes all protected health information under the Health Insurance Portability and Accountability Act of 1996,45 Code of Federal regulations section 164, and all other applicable federal statutes and regulations (hereinafter referred to as "Act") as well as 63 O.S> 1-502.2, 43A O.S. 1-109, and all other applicable Oklahoma Statutes regulations (hereinafter referred to "statues") for the purpose of determining the best course of treatment for my child.

2. My minor child's individually identifiable health information and other medical information including protected health information under the Act and Statutes may be obtained or disclosed at the request of _____, Pathfinder leader.
3. The above covered entity is authorized to make the requested use or disclosure.
4. Any covered entity is authorized to disclose the protected health information referred to in paragraph 1 and 2 above to the name leader. The covered entity will not be compensated for disclosure to the recipient except for the cost of copying and mailing as authorized by law.
5. The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the parents or legal guardians sign this authorization.
6. I recognize that I have the right to revoke this authorization in writing at any time except when lacking capacity or competence. I may revoke this authorization in writing to the leader named above and/or covered entities. I recognize that revocation of this authorization in writing as specified above does not apply to protected health information already disclosed in response to this authorization.
7. I recognize that the protected health information disclosed by covered entity under this authorization may be subject to re-disclosure by the recipient and is no longer protected by this Act and/or Statue.
8. I understand that the information authorized for release may include records which may indicate the presence of a communicable disease.

_____ _____

Parent or legal guardian (*underline which*) Date

NOTICE OF RIGHTS: Information in your child's medical records that he or she has or may have a communicable or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons when have had risk exposures, disclosure pursuant to an order of the court of the Department of a Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which your child could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by Law.

Permission for Photographing Your Child

The Church and Oklahoma Conference take pictures and/or conducts video recordings during the events and activities. We would like your permission to take pictures and videos on your child and use these pictures and videos on our website, in our newsletter, and the Adventist Publications/Websites. We will not reference your child by name or provide any specific information regarding your child. In addition, we do not sell these pictures and videos or use them in any other way.

Yes_____ No_____

_____ _____

Parent /Guardian's Name PLEASE PRINT Parent/Guardian's Signature: (*underline which*)

_____

Date