The Heart Institute Family Retreat Weekend
Sibling Information

Child's name:_____ Age:_____

Does your child function at his or her age level?___ If no, please describe_____
_____
_____
_____

Describe any serious fears your child has: _____
_____
_____

Describe any medical or emotional needs about which we should know:_____
_____
_____
_____

For campers ages three and under: Please provide information about their daily routines (naptimes, mealtimes, likes/dislikes, comfort items, etc.)
_____
_____
_____
_____
_____
_____
_____
_____

Cincinnati Children's

Authorization for Use and/or Disclosure of Limited Protected Health Information

MEDICAL RECORD #: _____ *(completed by CCHMC if applicable)*

****DO NOT USE THIS FORM FOR RESEARCH PURPOSES OR TO RELEASE COPIES OF THE MEDICAL RECORD****

This form gives permission for Cincinnati Children's Hospital Medical Center (CCHMC) to use and/or disclose (release) the health information of the individual below as follows:

Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Address City State/Zip

Primary contact e-mail: _____ Phone: ( ) _____

Information To Use/Disclose

CCHMC may use/disclose the following health information about the individual: *(Select all that apply)*

- ☐ Photographs
- ☐ Video recordings
- ☐ Audio recordings
- ☐ Name and age
- ☐ Parent/guardian names
- ☐ City of residence
- ☐ Admission, discharge, or treated/released status
- ☐ Diagnosis, treatment, prognosis
- ☐ All of the above
- ☐ Other:_____

Purpose of Use/Disclosure

CCHMC may use/disclose this health information for the purposes described below: *(Select all that apply)*

- ☐ CCHMC communications, such as for marketing, advertising, public relations, fundraising, or other related purposes. This may include publications (print or electronic), presentations (at public or private events, on television), or internet sites (e.g., CCHMC websites, partner websites, or social media sites).
- ☐ The media, including print or television journalists.
- ☐ Professional audiences, such as publications (print or electronic), presentations or related internet sites.
- ☐ All of the above
- ☐ Other: _____

_____

By signing below, I authorize CCHMC to use and/or disclose the health information specified in this authorization and confirm to the best of my knowledge that I am legally authorized to represent the interests of this individual.

- CCHMC will not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization.
- The health information used and/or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information. At that point, it is no longer protected by the federal privacy regulations. CCHMC is not responsible for the use of information, in whole or in part, by third parties.
- Any photos, images, or other representations specified above become the property of CCHMC or its representatives.
- This authorization is given without promise of compensation. The parent/legal guardian and the individual release to CCHMC any right, title and/or interest of any kind they may have in the information or images produced.

As stated in the Notice of Privacy Practices, I understand that I may withdraw this authorization at any time. Notification of withdrawal must be done in writing and sent to the CCHMC Health Information Management (HIM) Department, 3333 Burnet Avenue, ML 5015, Cincinnati, OH 45229. This authorization will not be withdrawn or expire for situations where CCHMC has already taken action as described in this authorization. This authorization will only expire if revoked by me in writing as stated above.

Signature: _____ Date: _____

Printed name:_____

This form must be signed and dated to be valid. If the individual is an emancipated minor or 18 years of age or older, s/he is required to sign the authorization.

A copy of this authorization must be provided to the individual completing this form.

CCHMC USE ONLY

Department requesting authorization: _____

*Note: The original, signed authorization must be sent to the HIM Department Attn: ECRM (MLC 5015) within 2 weeks of obtaining signature. The department obtaining this authorization must also retain a copy, either on paper or electronically, for internal tracking purposes.

CAMPER NAME_____

The Heart Institute Family Retreat Weekend
CCHMC
Acknowledgment of Risk and Release Form

- I understand that my participation in programs offered by Cincinnati Children's Hospital Medical Center (CCHMC) is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.
- I am aware that experiential outdoor pursuits such as climbing, hiking, high ropes courses, ground initiatives, and other activities provided by CCHMC at Joy Outdoor Education Center for which I and/or my child have enrolled entails certain risks.
- Therefore, for myself/my child, I expressly, knowingly and voluntarily assume all risks involved in my participation, and do hereby release CCHMC and its members, trustees, officers, employees, and independent contractors and agents from any and all liability, damages, costs, and expenses arising out of or relating to bodily injury, loss of life or personal property that may occur as a result of participating in this program.
- I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding on the parties during ht entire period of participation in the said program.
- Authorization for treatment- I hereby give permission to the medical personnel selected by the CCHMC to arrange necessary related transportation for this participant and assist with the prescription and over-the-counter medication if needed. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by CCHMC or Camp Joy to secure and administer treatment, including hospitalization, for the person named above.
- I acknowledge that the accommodations consist of large cabins which will house several families. CCHMC encourages all participants to bring only the minimum articles and personal items necessary for a comfortable weekend. CCHMC assumes no responsibility or liability for any lost, missing or stolen personal items.
- I understand that the participants on the Retreat Weekend will be made up of patients and families from The Heart Center. CCHMC assumes no responsibility or liability for any injury suffered as a result of the behavior of other participants.
- I give my consent for myself or my child to be photographed or videotaped for general camp, website, and/or CCHMC publicity.

_____ _____

Required: Signature of participant date Signature of parent (If participant is under 18)

Note: This participant shall not be permitted to participate in the following activities:_____

_____

_____

JOY OUTDOOR EDUCATION CENTER

MEDICAL FORM & ACKNOWLEDGMENT OF RISK and RELEASE (printed on Back)

INSTRUCTIONS: Please read and complete this form carefully. **PLEASE PRINT**

PARTICIPANT'S LAST NAME: _____ **FIRST:** _____ **Circle One**: Chaperone / Participant

Circle One: Male / Female **Participant's Birth Date**: ___/___/___ **Age:** ____ **Email:** _____

Street Address: _____ City _____ State_____ Zip: _____ **Phone** (___)_____

Primary Contact:_____ **Relationship**: (Parent / Guardian / Spouse / Other): _____

Primary Contact #.'s: Home: (____)_____Work: (_____)_____Cell/Other: (_____)_____

IF PRIMARY CONTACT IS NOT AVAILABLE - IN AN EMERGENCY NOTIFY: (List 2 contacts at 2 different addresses)

1. Name: _____ Relationship: _____
Address: _____
Home # (_____)_____ Work # (____)_____
Cell # (_____)_____

2. Name: _____Relationship:_____
Address_____
Home # (____)_____ Work # (____)_____
Cell # (_____)_____

PHYSICIAN & INSURANCE INFORMATION

Medical/Hospital Plan: _____
Policyholders First & Last Name:_____
Primary Physician's Name:_____
Family Dentist's Name:_____

Policy or Group #: _____
Employer:_____
Phone:(___)_____
Phone: :(___)_____

MEDICATIONS

Prescribed Medicine Name / Reason
1. _____
2. _____

Immunizations: DPT Date_____ Tetanus Date_____

Have you had Chicken Pox? Circle: Yes No

List any dietary restrictions:_____

List any activity restrictions: _____

List anything else, which would help us, better serve you: _____

MEDICAL CONDITIONS

- ☐ Asthma (Does participant carry an inhaler?) ____
- ☐ Broken Bones
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Infectious Hepatitis
- ☐ Psychiatric Care
- ☐ Pregnancy
- ☐ Fainting
- ☐ Convulsions / Seizures / Epilepsy Date of last Seizure:___/___/___

ALLERGIES: Check all that apply

- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Poison Ivy, other plants:_____
- ☐ Peanuts, other foods: _____
- ☐ Penicillin, Other drugs:_____
- ☐ Latex

Describe Allergic Reaction:_____
_____
_____

Does participant carry an Epi-pen? _____
(If yes, please send Epi-pen with participant and ensure s/he knows how to use it safely.)

Please describe management of the above conditions / allergies:_____
_____

Describe and give dates of any hospitalizations, serious injuries or recurring illnesses:_____
_____

Acknowledgment of Risk and Release

Revised 1/15/2010

INSTRUCTIONS: Please read this form carefully. EACH PARTICIPANT MUST SIGN THIS ACKNOWLEDGMENT OF RISK FORM BEFORE the program begins. Without all appropriate signatures, the individual may not be permitted to participate in the program.

I understand that my participation in programs offered by Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., (JOEC) is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.

I am aware that experiential, outdoor pursuits such as living history reenactments, climbing, hiking, high ropes courses, ground initiatives, and other activities at JOEC, for which I have enrolled, entail certain risks.

I understand that completing and signing the Center's Confidential Medical Information Form is a prerequisite to participate in this program. The information my child or I have provided is a complete and accurate statement of the physical and psychological factors, which may affect participation in the program.

Therefore, I, for myself and for my heirs, personal representatives, and assigns, and each of them, forever release and fully discharge Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., and each of their members, managers, directors, employees, volunteers, agents, officers, predecessors, affiliates, representatives, successors, and assigns, and each of them, from any and all actions, causes of action, claims, costs, damages, demands, fees, and/or liability of any kind, nature, or descriptions whatsoever, whether know or unknown, arising out of or in any way related, whether directly or indirectly, to participation in any JOEC program, including, but not limited to any physical injury, psychological injury, loss of life or personal property that may occur as a result of participating in this program.

I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the parties during the entire period of participation in the said program.

I understand that photography is a standard component during JOEC programs. I consent for myself and/or my child/minor of legal responsibility to be photographed for general program and/or agency printed/internet publicity.

The health history is correct as far as I know, and the named participant has permission to engage in all prescribed program activities, except as noted. **Authorization for treatment**: I hereby give permission to the medical personnel selected by the visiting organization to arrange necessary related transportation for this participant and the visiting organization or JOEC to secure and administer treatment, including hospitalization, for the person named above.

_____ _____

Signature of participant (REQUIRED) Date If participant is under 18, Date
(Signature of Parent or Guardian is REQUIRED)

NOTE: This participant shall **NOT BE PERMITTED** to participate in the following activities:

_____

☐ Check this box to decline the photo release.