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Medical Information/Informed Consent/Hold Harmless Agreement

Name _____ Date _____ Date of Birth _____

Address _____

Telephone # _____

Name of personal Physician _____

In case of emergency contact _____

Phone # _____

List known Allergies _____

If you are allergic to bee stings, do you have a bee sting kit? _____

Do you wear contact lenses? _____ Are you pregnant? _____

Have you had or do you have COVID-19? Diabetes Asthma Angina Epilepsy _____

Chest pain Drug reactions high blood pressure heart murmur _____

Heart attack (if yes, date) _____

Have you ever had any serious disease or surgery? (If yes, explain and include date) _____

Do you have any other medical conditions we should be aware of? _____

I understand that participation in the following activity offered through the Pennsylvania Dutch Council, BSA, on SEP 20, 2024, involves certain degree of risk that could result in injury or death. In consideration of the benefits to be derived and after carefully considering the risks involved, and in view of the fact that the Boy Scouts of America is an organization in which membership is voluntary, and having full knowledge that participation will be done to ensure the safety and well-being of my child, I give my permission for my child to participate in the hold harmless and waive any claims I may have against the Pennsylvania Dutch Council, BSA, the National Council BSA, and its chartered affiliates, agents, servants, employees, officers from all cost and expenses including but not limited to, attorney's fees, reasonable attorneys' fees, court costs, expenses, and all other costs the above mentioned persons may pay or become obligated to pay on account of any, all and every demand for claim or recovery of liability, or any claim or action brought herein arising or alleged to have arisen out of your child's use of and or personal property belonging to the Pennsylvania Dutch Council, BSA or by any action or omission by your child. In case of emergency, I understand every effort will be made to contact me. In the event a claim is brought, I hereby give my permission to the physician selected the child leads to obtain to secure proper treatment, including hospitalization, anesthesia, surgery, or operation or medication for my child.

This form must be signed by both parents/guardians

I am not under the influence of any chemical substance including alcohol. Understanding that any physical activity involves the risk of injury I understand that my participation in the Pennsylvania Dutch Council, BSA, council BSA and all its employees from any claim or liability arising out of my participation. The release does not, however, apply to any harm caused by negligence or willful misconduct of the Pennsylvania Dutch Council, BSA or its employees.

Name (print) _____ Consent date _____

Participant's signature: _____ Date _____

If participant is under age 18, his or her parents or guardians must also sign below

Parent/guardian Signature(s) _____

Parent/guardian Signature(s) _____

For application use only: Boy Scout Training/COP/ Medical



10000 UNIVERSITY AVENUE, SUITE 1000, DALLAS, TEXAS 75243

CONSENTIMIENTO GENERAL PARA TRATAMIENTO MEDICO Y DENTAL

Patient ID # _____

Nombre del Paciente: _____ Fecha de nacimiento: ____/____/____

- Entiendo y entiendo los riesgos médicos y quirúrgicos en Cornerstone Family Healthcare y los procedimientos a seguir los servicios que pueden ser parte de un diagnóstico médico, procedimientos para tratar mi enfermedad y cualquier tratamiento de rutina dental o médico. Entiendo que estos servicios están ofrecidos por un médico, dentista, enfermero, asistente médico y otros proveedores de salud, algunos de los cuales podrían estar en proceso de certificación. No se me han brindado garantías en cuanto a los resultados de los servicios que voy a recibir.
- Entiendo que mi acuerdo en aceptar estos servicios no constituye en efecto o motivo para no indicar que no deseo continuar recibiendo estos servicios o para que mi tratamiento sea luego completado.
- Entiendo que mi acuerdo en aceptar estos servicios es llamado "Consentimiento General" y que incluye procedimientos de rutina o tratamientos tales como: pruebas de sangre, examen físico, administración de medicamentos, tomar rayos x, uso de anestesia local o cualquier otro tratamiento no quirúrgico.

Firma del Paciente/Padre/Madre/Guardian del Paciente Menor de Edad _____ Fecha _____

Si el paciente no puede consentir por cuenta propia, se requiere la firma del agente a cargo de su salud, el representante legal, o el familiar más cercano quien dará consentimiento para tratar al paciente.

Firma del Agente Asignado por Corte o Representante Legal _____ Fecha _____

Firma y Relación de Familiar Más Cercano _____ Fecha _____

Testigo: _____ Yo, _____ soy un empleado de Cornerstone Family Healthcare y no proveedor de salud. Soy testigo de que el paciente o alguna persona pertinente al mismo ha firmado este documento.

Firma del Testigo _____ Fecha _____

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Medical Treatment Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should be given to the trip leader or shown to the trip leader and then carried by the designated adult.

Minor

Full Legal Name: _____

Home Address: _____

Date of Birth: _____ Gender: Female _____ Male _____

Information for Medical Treatment

Physician's Name and Location of Practice: _____

Physician's Phone # (if known): (____) _____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____

Allergies (Other): _____

Please note **all** conditions for which the child is currently receiving treatment:

Note any other significant medical information: _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for _____ (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through: _____ Signed this _____ day of _____, 20____.

Parent / Legal Guardian Signature: _____ Printed Name: _____

Witness Signature: _____ Printed Name: _____

Medical Consent Form [Template]

I, the parent or guardian of:

_____ [mention the patient's name]

Hereby, give my permission in full consciousness to the media staff/personnels/volunteers who are involved and participating in the activity being carried out during the period of:

_____ [mention the date of event]

To administer any possible relevant medication and treatment with the benefit of the named patient, when or if necessary, I shall be responsible for informing the organized club regarding the medication requirements and any known medical condition.

In addition to this, in any case when the condition becomes worse or if any case arises then, I give authorization to the members of medical staff/personnel/volunteers to take my daughter/son to the clinic/hospital and give entire permission to them for carrying out any sort of the treatment or medical procedure which is required to be carried out in accordance with the diagnosis performed by hospital/clinic. I comprehend, I shall be notified about the hospital/clinic visit and the medical treatment provided by the hospital, as early as possible.

Parent/Guardian Consent:

[Signature of the parent/guardian]

[Mention the date]

[Mention the name]

[Mention the Relationship to the Participant]

Child _____

Attending workshop / training camp: _____ On (Date) _____

Address: _____ Post _____

Email: _____ DOB: _____ Age: _____

Mobile/Contact No: _____ Must be contactable on the day.

1. I, (parent if under 18) _____, hereby, Manager, or designated Staff representative, to seek medical aid in the event of an accident, injury, Participant

2. General medical aid, including transport, will be at the discretion of the Program Manager, or

In addition:
Specific permission, on appropriate medical advice, is given for the following:

Does your child have any behavioral/learning difficulties that we should be aware of: ☐ Yes

Has your child had an injury/illness in the past 12 months? _____ Details if yes _____

Has your child been cleared to participate in an active program? _____

Does your child suffer from any condition that could involve hospitalization (eg. asthma, Bronchitis etc)? ☐ Yes ☐ No If Yes, please state: _____

Known Allergies: _____

Home About Organizations Resources Blog News Team Contact Download guidance Decision-making and consent (English) Decision-making and consent (Welsh) The General Medical Council has published a new guide entitled "Decision and consent". This guide comes into effect on 9 November 2020 and replaces the 2008 orientation, "Conseent: patients and doctors who make decisions". The new guide is relevant to every health and care decision a doctor commits with a patient and reaffirms consent as a fundamental legal and ethical principle that underpins good practices. Doctors must be satisfied that they have the consent of a patient or other valid authority before providing treatment or care and the purpose of guidance is to help doctors comply with this standard. Those familiar with the 2008 orientation will appreciate that the changes in the updated guide are killed. This reflects the fact that the Basic Law on Mental Capacity and Decision-making is now well established throughout the United Kingdom and only minor adjustments are being made, as the case law is being developed. However, the new guide is better structured and shorter, making it more accessible and easier to digest. It also identifies seven underlying key decision-making and consent principles that provide a useful summary for those who want a quick overview (page 7). What else is there again? The guide asks doctors to adopt a proportional approach to their implementation. It is clear that not all paragraphs will be relevant to each decision and that such a professional judgement on the implementation of guidance should be based on the specific circumstances of each decision (para. 5). The guide also provides a useful checklist for routine, fast and non-invasive procedures in which it can bethat a doctor depends on the patient's non-verbal consent (paragraph 7). The updated guide provides a greater focus on the patient's doctor's dialogue that is critical to good decision-making (paragraph 8) and should beto every patient. A new section (paragraphs 16 to 20) helps doctors find out what matters to a patient, requiring them to study their needs, values, and priorities, as well as their desires and fears about their health. This information will allow doctors to avoid assumptions and better understand what information your patient may need to evaluate treatment and care options and ultimately make an informed decision. There is also a new section (paragraphs 25 and 26) that provides guidance to physicians on how to deal with uncertainty in a diagnosis, treatment, or assessment of an option in the decision-making process. This requires physicians to be honest with the patient about any questions and to be clear about the limits of their own knowledge when answering questions. The new guidance adopts the term "relevant information" used in the Mental Capacity Act 2005 and the related Code of Practice, and emphasizes that relevant information must be shared with patients so that they can understand and retain it. More details are given on how to achieve this, including taking into account the patient's wishes if he wishes to record the debate or use a translation service (paragraph 27). The guide suggests a team-based approach to meeting the patient's information needs, drawing on the experience of team members who may be aware of a particular condition, be qualified communicators, or have a relationship of trust with the patient (paragraph 41). move forward, while recognizing that this will be an ongoing dialogue (paragraphs 32 to 39). Any such discussion should be recorded in the patient's notes, including all practical details about the patient's wishes and fears, their preferences about future care options and the values and values of the patient. which influence their decision-making. Whether there is a possibility that the patient may lose the capacity, if possible, if possible, while the patient has the capacity to review and understand it (paragraph 37). The updated guidance contains a summary of the legal framework, particularly where a patient may lack the ability to make a decision, but also includes advice for situations where doctors may have a concern that a patient may not be able to make a decision freely. (paragraphs 69 ~75. 75). Examples are provided when patients may be vulnerable or susceptible to pressure and the guidance is explicit that physicians should follow local safeguard procedures if they have concerns that patients' rights are being abused â. The complete guide is available here. We can help our team around the clock to provide urgent legal advice ranging from general advice, to finding out if a court application is needed, preparing witnesses and evidence, and providing legal representation at any hearing. For more information, contact Ruth Atkinson-Wilks. Atkinson-wilks. These Council reports advocate policies on emerging delivery systems that protect and foster the patient/physician relationship. Key Council reports on this topic have addressed patient-centered medical homes, precision medicine, APMs, telemedicine, and retail and store-based health clinics. 20.09.2021 · What are medical ethics? Medical ethics are guidelines that all medical practitioners should adhere to when treating people. They are basic human rights principles, and they are considered best practices in public health matters. In the interest of providing informed consent, health care providers should consider all pillars of medical ethics. 03.06.2015 · Punishment & Disciplinary Action Complaints heard by Medical Council of India (MCI) - as an apex body If appropriate medical council's decision is not acceptable, the petitioner or the RMP may then appeal to MCI within 60 days from the date of receipt of the order. If no action is taken by appropriate medical council within 6 months, then the ... As a general rule, there is no need to record assessments of capacity to take day-to-day decisions. Remember in order to have protection from liability when providing care or treatment, staff must have a reasonable belief that the person they care for lacks capacity to make relevant decisions about their care or treatment (see section 5 (1) MCA). 25.10.2021 · If a patient requests a temporary vaccination exemption on the grounds of a past COVID-19 infection, Dr Martine Walker, medical advisor at the Medical Council, suggests asking for the patient's consent to contact the relevant lab ...

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