Participant's name: _____ Date of birth (include year):_____

HYLAX has partnered with Texas Children's Hospital and/or Baylor College of Medicine to provide services during HYLAX Season events. There is not a charge for these services; no billing information will be exchanged.

General Consent to Treat

I have the legal right to consent to medical and surgical treatment because I am the parent/guardian of the above named participant. I voluntarily authorize and consent to initial assessment and treatment by Texas Children's Hospital, Baylor College of Medicine and/or their designated associates or assistants. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers working under the partnership between Texas Children's Hospital and *HYLAX Season* to provide treatment until I withdraw this consent. **I understand that staff from Texas Children's Hospital and/or Baylor College of Medicine will only provide initial assessment and treatment, and subsequent care, if any, will be obtained at my discretion.**

I understand Texas Children's Hospital and/or Baylor College of Medicine personnel are not my child's personal healthcare providers and are offering their service's only as part of their partnership with *HYLAX*. I understand I should contact my child's medical provider if I have questions after these events.

_____ (Please initial)

Authorization to Disclose Information to *HYLAX*

Texas Children's Hospital and/or Baylor College of Medicine providers will document services provided to participants on the "Texas Children's Hospital SOAP Note." A SOAP Note contains information including the participant's vital signs and measurements, findings from physical examinations, medical diagnosis, and plan of care. By initialing below, I hereby authorize Texas Children's Hospital and/or Baylor College of Medicine providers to disclose any Texas Children's SOAP Notes and personal health information learned by providers during the course of providing services to the above named participant to *HYLAX Season* staff members.

I understand and agree to the following:

- If I refuse to sign this consent and authorization, Texas Children's Hospital and/or Baylor College of Medicine personnel will not be able to provide services to the participant at *HYLAX Season* events.
- I may revoke this authorization at any time by notifying Texas Children's Hospital and *HYLAX* in writing. If I revoke the authorization I understand that it will have no effect on actions Texas Children's Hospital took in good faith before receiving the revocation.
- If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- Texas Children's Hospital reserves the right to verify my identity/guardianship.
- This authorization expires one year from the date of my signature unless another date is specified here:_____

_____ (Please initial)

Name of Participant's Legal Representative: _____

Relationship of Participant's Representative if patient under 18: _____

Signature of Participant's Representative: _____Date: _____

The participant's legal representative must be provided with a copy of this form.