Bethell Hospice Services
PARENTAL CONSENT

NOTE: Please complete this form for all minors under the age of 18.

CHILD'S INFORMATION: **InfoAnywhere # (Internal Use ONLY):** _____

PREFERRED PRONOUN: ◯ **HE** ◯ **SHE** ◯ **THEY** ◯ **ZE** **OTHER:** _____

FIRST Name: _____ **LAST Name:** _____

DATE of Birth: _____

My child has the following medical conditions: ◯ **NONE or** _____

_____

My child has the following allergies: ◯ **NONE or** _____

My child takes the following medications (*please provide details*): ◯ **NONE or** _____

_____

PRIMARY PARENT OR GUARDIAN INFORMATION: **InfoAnywhere # (Internal Use ONLY):** _____

PREFERRED PRONOUN: ◯ **HE** ◯ **SHE** ◯ **THEY** ◯ **ZE** **OTHER:** _____

FIRST Name: _____ **LAST Name:** _____

RELATION to the Child: _____

ADDRESS: _____

PHONE (*Home*): _____ **(*Cell*):** _____

EMAIL: _____

In the event of an emergency, if the parent/guardian is unavailable, please contact:

Emergency Contact INFORMATION: **RELATION to Client? :** _____

PREFERRED PRONOUN: ◯ **HE** ◯ **SHE** ◯ **THEY** ◯ **ZE** **OTHER:** _____

FIRST Name: _____ **LAST Name:** _____

PHONE (*Home*): _____ **(*Cell*):** _____

The mission of Bethell Hospice is to provide excellent person-centered, palliative care through partnerships within our community. Values of the organization include: Compassion, Integrity, Accountability, Excellence, Teamwork and Courage.

FAMILY DOCTOR *(or other professional involved in your care)*:

NAME: _____

TYPE of Professional: (*i.e. Family Doctor, Care Coordinator, Social Worker etc.*): _____

ADDRESS: _____

PHONE: _____

◯ **CONSENT for Service:**
• I hereby give consent for my child to take part in the Bethell Hospice Community Support Programs, one on one or and/or in a group setting.
◯ **MEDICAL Emergencies:**
• I agree that in the event of a medical emergency, if medical treatment is required, I will be notified and my child will be transported to a medical facility or 911 will be called. A doctor has the right to insist on parental consent prior to treating a child.

◯	**PRIVACY and Confidentiality**

- I understand that all personal information will be treated as private and confidential as per the Personal Health Information Protection Act, 2004.
- I understand that information sharing between Bethell Hospice personnel shall be for the sole purpose of providing quality service to meet my needs and those of my family. I understand that all personal information will be treated as private and confidential. Safety supersedes confidentiality when persons are at risk.

◯	**VOLUNTEERS:**

- I understand that volunteers are part of the Bethell Hospice team who are trained to work in specific roles and contribute to my child's experience while enrolled in service with Bethell Hospice.

◯	**WAIVER:**

- I understand and accept the conditions noted above. I agree to release and indemnify Bethell Hospice or any directors, officers, volunteers, agents and employees from all claims and liability for any of the following:
    1. Personal injury, illness, incapacity, or death that occurs, or
    2. The loss of money, valuables and personal effects unless held in safe keeping by the Hospice
    3. Loss of property or damage (unless intentionally committed)
    4. Any care provided to me other than by the employees and agents of the Hospice
- I agree to release Bethell Hospice along with its directors, officers, volunteers, agents and employees of all actions, claims or demands of any nature or kind arising out of, or in any way connected with the provision of services by Bethell Hospice except if claims arise from intentional or deliberately harmful or criminal actions.

◯	**FEES for Service:**

- I understand that the services of the community support programs are provided at no cost thanks to the generosity of donors, community partners and government funding. Financial donations, in-memoriam donations and bequests are gratefully accepted. To discuss donation opportunities, please contact the Foundation office at foundation@bethellhospice.org.

◯	**AODA Statement**

- Bethell Hospice is committed to providing an accessible experience in which all individuals have equal access to our services and facilities as required by the Accessibility for Ontarians with Disabilities Act, 2005

I further recognize that circumstances and information can change, and it is my responsibility as parent/guardian to notify the organization so necessary changes can be made to my child's existing form, or a new one can be completed.

◯ **PRIMARY PARENT** **OR** ◯ **GUARDIAN**

PRINT Name: _____

Signature: _____

Dated: _____