

Name: Last _____ First _____ Program Name _____

Dear Parent/Guardian,
It is essential that we have the medical and emergency information requested below. Our goal is that every participant experience is a safe and healthy time at Crestfield. Thank you for your time and attention in helping us achieve this goal. The Crestfield Staff



Participant's Name _____

Address _____
Last First Middle

Street City State Zip

Phone _____ Child's DOB _____

Parent/Guardian Name _____

Address or phone if other than above _____

In case of emergency if above not available, please notify:

Name _____ Phone _____

Address _____

Street City State Zip

In case there is a need for medical attention, we will make every effort to contact the persons listed above for permission to treat. Your family policy is the primary health and accident coverage; Crestfield provides only secondary health and accident coverage. We therefore need the following information in order to care for your child. Please be sure to complete both sides of this form and sign the consent statement on the reverse side. Please provide a copy of both sides of your child's insurance card.

Health Insurance Carrier _____ Name of Insured _____

Policy No. _____ Group No. _____

DOB of Insured _____ SSN of Insured _____

Has your child received all immunizations required for school entrance? Yes [] No []

Has your child received a tetanus shot in the last ten (10) years? Yes [] No []

If yes, give date: _____ If no, please make sure your child gets a tetanus shot before coming to camp.

Has your child been sick in the last two weeks prior to attending Crestfield for this program? Yes [] No []

Has your child been in contact with anyone with a contagious disease within the last two weeks? Yes [] No []

If yes, what? _____

Does your child have any skin irritation or infection at the present time? Yes [] No []

If yes, what? _____

Allergies: No known allergies; this camper is allergic to: food; medicine; the environment (insect stings, hay fever, etc.); other. Please describe below what the camper is allergic to and the reaction seen.

Diet & Nutrition: This camper eats a regular diet; this camper eats a regular vegetarian diet; this camper has special food needs. Please describe below.

If you have specific dietary needs, please contact our Food Service Director at 724-794-4022.

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions; I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. Please describe below.

Medication: this camper will not take any daily medications while attending camp; this camper will take the following daily medications(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medication brought to Crestfield must arrive in the original pharmacy container with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp. All medication will be stored and administered by the Crestfield Health Care Manager.**

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should NOT be given.**

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Aloe
Phenylephrine decongestant (Sudafed PE)	Pseudoephedrine decongestant (Sudafed)	Sore throat spray
Antihistamine/allergy medicine	Guaifenesin cough syrup (Robitussin)	Generic cough drops
Diphenhydramine antihistamine/allergy medicine (Benadryl)	Dextromethorphan cough syrup (Robitussin DM)	
Calamine Lotion, CalaGel, 1% hydrocortisone cream	Antibiotic cream	
Dextromethorphan (Guifenissen)	Bismuth subsalicylate for diarrhea or upset stomach (Kaopectate, Pepto-Bismol, Tums)	

Check box(es) if camper has any of the following:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Bee sting allergy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Depression/anxiety problems |

Has the camper had a significant life event that continues to affect the camper's life? Yes [] No []
 (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others.) If yes, please explain _____

Other comments or suggestions as we strive to provide the best possible care for your child:

Primary Care Physician _____ Office Phone: _____

Address _____
Street City State Zip

Date of last physical exam: _____

The American Camp Association (ACA) recommends campers have a physical examination by their physician within two (2) years prior to attending camp.

Parental/Guardian Consent Statement:

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Photos of this person may be used by the camp. I give my permission to allow my child to participate in transportation for Crestfield sponsored events off of camp property. I will hold harmless Crestfield in any case of injury or illness. I will notify the camp Health Care Administrator of any medical problems or restrictions prior to the program period. **Authorization for treatment:** I hereby give permission to the medical personnel selected by the Crestfield director to order X-rays, routine tests, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Crestfield director to secure and administer treatment, including hospitalizations, for my child as named above. This form may be photocopied for trips out of Crestfield.

Parent/Guardian Signature: _____ Date _____

Witness Signature: _____ Date _____

Health Center Use Only!

Date: _____

Check in: _____

Comments: _____