

Name: Last, First \_\_\_\_\_

Retreat Name \_\_\_\_\_

## Adult Health Form



*Dear Participant, It is essential that we have the medical and emergency information requested below. Our goal is that every participant have a safe and healthy experience at Crestfield. Thank you for time and attention in helping us achieve this goal. This information will be kept confidential, in compliance with HIPPA (Health Insurance Portability and Accountability Act) standards.  
The Crestfield Staff*

**Participant's Name** \_\_\_\_\_

Last, First, Middle

**Address** \_\_\_\_\_

Street, City, State, Zip

**Phone** \_\_\_\_\_

**DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_

**If not available in Emergency, 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.*

**Do you have any known allergies (food, drug, pollen, And/or insect)?**

**Do you have any health conditions that may restrict your ability to participate fully in activities at Crestfield?**

**Are you currently taking any prescribed medication on a regular basis?**

**Is there anything else regarding your health that would help us accommodate your needs while staying at Crestfield?**

**Consent Statement:**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. I give Crestfield permission to use photos of this person for publicity purposes. I will hold harmless the camp in any case of injury or illness.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_