

Name _____ **SHCCM/Crestfield**

Dear Parent/Guardian,

It is essential that we have the medical & emergency information requested below. Our goal is that every participant experience is a safe & healthy time @ Crestfield. Thank you for your time & attention in helping us achieve this goal. The SHCCM/Crstfield Staff. ****BRING THIS FORM AND ANY MEDICATIONS WITH YOU FOR CAMP ARRIVAL AND CHECK IN.**

Participant's name _____
Last first middle

Address _____
Street city state zip

Phone _____ cell _____ Child's DOB _____ / Age _____

Parent /Guardian Name _____ email _____

Address or phone if different 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 & accident coverage;crestfield provides only secondary health & accident coverage. We therefore need the following information in order to care for your child.

Health Insurance carrier _____ Name of insured _____

Policy number _____ group number _____

DOB of insured _____

Has your child received all immunizations required for school entrance? yes no

Has your child received a tetanus shot in last 10 years ? yes no
If yes, give date _____ If no, please make sure your child gets tetanus shot prior to camp.

Has your child been sick in the last 2 weeks prior to attending this camp program? yes no
If yes, how? _____

Has your child been in contact with anyone with a contagious disease within the last 2 weeks? yes no
If yes, what? _____

Does your child have any skin irritation at the present time? yes no
If yes, what? _____

Allergies: no known allergies this camper is allergic to
 food medicine environmental(insect stings, hay fever ,etc.) other.

Please describe below what the camper is allergic to & the reaction seen:

Diet & exercise: this camper eats a: regular diet regular vegetarian diet special food needs.
Please describe: _____

Restrictions: camper has no physical restrictions. restrictions as listed below:

Medication: This camper will not take any daily medications while attending camp.

This camper will take the following daily medications while at camp:

“Medication” is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. All medications brought to Crestfield must arrive in the original pharmacy container with labels which show the camper’s name & 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 & administered by EFPCA Nurses.

medication	Reason for taking	When it is given	Dosage	Route administered

The following non-prescription medications are stocked by the EFPCA nurses & are used on an as needed basis to manage illness & injury. **Cross out those NOT to be given.**

Acetaminophen(Tylenol)	Ibuprofen(Advil, Motrin)	Aloe
Phenylephrine decongestant (Sudafed PE)	Antihistamine/allergy medicine	Antibiotic cream
Pseudoephedrine decongestant (Sudafed)	Diphenhydramine (Benadryl)	sore throat spray
Calamine lotion/1% hydrocortisone cream	Dextromethorphan/cough syrup (Guifenissen)	cough drops
Saline nasal spray	eye drops(Visine)	Aspirin
Anti-diarrheal	Orajel	Delsyn(cough syrup)

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 |

****Has the camper had a significant life event or other information 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, explain _____

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

Primary Care Physician _____ Office phone # _____

Address _____

Date of last physical exam _____ The ACA(American Camp Association recommends campers have physical exam by their physician within 2 years prior to attending camp.

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

Parent/Guardian Signature _____ Date _____

Comments: