

SUMMER 2024

CRESTWOOD COUNTRY DAY CAMP
SUMMER PROGRAM MEDICAL INFORMATION FORM

NAME AND PHONE OF INSURANCE CO.: \_\_\_\_\_

IDENTIFICATION NO.: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

NAME OF CHILD: \_\_\_\_\_ SEX: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_
(LAST) (FIRST)

ADDRESS: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ PARENT'S NAME: \_\_\_\_\_
WORK: \_\_\_\_\_ WORK: \_\_\_\_\_
CELL: \_\_\_\_\_ CELL: \_\_\_\_\_

IN CASE OF ILLNESS OR ACCIDENT, NOTIFY: Nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached:

1) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ OR 2) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_
(NAME) (PHONE #) (NAME) (PHONE #)

ALLERGIES (ASTHMA, DIABETES, SEIZURES, ETC) OR SPECIAL CONDITIONS PLEASE EXPLAIN:

CHECK ILLNESSES/MEDICAL ISSUES THAT CHILD HAS HAD WITHIN THE PAST YEAR

- APPENDICITIS EAR INFECTION/TUBES MUMPS CONCUSSION
MOLLUSCUM FREQUENT COLDS POLIO TONSILLITIS
CHICKEN POX GERMAN MEASLES RHEUMATIC FEVER TUBERCULOSIS
DIPHThERIA MEASLES SCARLET FEVER WHOOPING COUGH

OPERATIONS OR RECENT ILLNESS: \_\_\_\_\_
CURRENT PRESCRIBED MEDICATIONS: \_\_\_\_\_

For the benefit of your child, the Directors should be made aware of any treatment for emotional, neurological, physical or psychiatric disorders. Does your child receive any special services in or out of school? If yes, please detail on the back of this form. In addition, any child who presents a risk to themselves or others, may be discharged from Crestwood at the discretion of the Directors. In the event I/we cannot be reached by phone, I/we hereby give permission to any local doctor or hospital and Crestwood Country Day to administer emergency treatment to my child/ren. I, \_\_\_\_\_ parent/guardian of \_\_\_\_\_, authorize any physician, nurse or other health care provider, to communicate with the medical staff and Directors of Crestwood Country Day, his/her designee, about my child's medical condition, treatment/or prognosis. I/we further authorize the medical staff of Crestwood Country Day to discuss with the Directors, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child. I/we consent to have our child use sunscreen she/he has brought in or the camp has supplied, which is approved by the FDA for over the counter use to avoid overexposure to the sun. Our child may be assisted by unlicensed camp staff if she/he requests. I/we also consent, if applicable, that my/our child may carry and use insect repellent or be assisted in the application thereof by an unlicensed staff member when requested.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

(TO BE FILLED IN BY MEDICAL DOCTOR)

NAME OF CHILD: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ LBS
IMMUNIZATION UPDATE:

- DPT(or DT,) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ CHICKEN POX \_\_\_\_\_ Chest X-ray \_\_\_\_\_
DPT(or DT,)Booster \_\_\_\_\_ Hep B \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Lead Screening \_\_\_\_\_
MMR \_\_\_\_\_/\_\_\_\_\_ Other \_\_\_\_\_ Sickle Cell Test \_\_\_\_\_
Tetanus Booster \_\_\_\_\_/\_\_\_\_\_ POLIO(TOPV) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Additional Procedures \_\_\_\_\_
HIB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ TB Screening \_\_\_\_\_

I have examined the above patient on \_\_\_\_\_. (Must be on or after 6/27/23) Camper is in good health and may participate in all activities without restrictions, except as noted:

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ PHONE:(\_\_\_\_) \_\_\_\_\_
PHYSICIAN'S PRINTED NAME \_\_\_\_\_ DATE: \_\_\_\_\_