SUMMER 2025

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 6/30/24**) 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:_____