



PineCrest
Conference Center
Assemblies of God

Individual Health Release Form

CAMPER / STAFF REGISTRATION (This is required by anyone staying as Pinecrest)

Date attending camp: Month: July/Aug? Day: 29th - 2nd Year: 2019
Church / Group name: The Bridge Church / Group phone: 951-600-9112
Name: _____ Gender: M ☐ F ☐
Address: _____
Home phone number: _____ Cell phone: _____ E-mail: _____
Parent or guardian: _____
School Attending: _____ Grade: _____ School District: _____

CAMPER / STAFF HEALTH INFORMATION

Name of Primary Medical Insurance: _____ Policy# _____
Physician name _____ Physician phone # _____
Does camper have any allergies you would like us aware of? _____
Does camper have any disease you would like us aware of? _____
Does camper have any dietary modifications? _____
Does camper have up to date immunizations? _____
Date of last known Tetanus shot? _____
Does Camper have any medical issues you would like us aware of? _____

Check ALL applicable conditions

- | | |
|--|---|
| <input type="checkbox"/> Bee Sting or insect Bite Reactions | <input type="checkbox"/> Recent Broken Bones or Other Injuries |
| <input type="checkbox"/> Food Allergies | Date of Injury: _____ |
| <input type="checkbox"/> Hay Fever/Sinus Problems | Type of Injury: _____ |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Sending RX | Activity Restrictions: _____ |
| <input type="checkbox"/> Back or Neck Problems | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Bed-wetting (currently) Bowel Problems | Date of surgery: _____ |
| <input type="checkbox"/> Epilepsy or seizure disorder Fainting | Type of surgery: _____ |
| <input type="checkbox"/> Headache | Activity Restrictions: _____ |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sleep walking (history of) |
| <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Sending Rx | <input type="checkbox"/> Diabetic <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 |
| <input type="checkbox"/> Child requires medical aide / supervision at all times | <input type="checkbox"/> Special Ed <input type="checkbox"/> EIP <input type="checkbox"/> Psychiatric / Emotional Illness _____ |

Non-Prescription Medication Available at Pinecrest

The medications listed below are kept in stock; do not feel obligated to send any of these items. Please check each box below to indicate your permission for the listed medication to be administered by your Groups Nurse or an authorized staff member. We will not administer any medication without your authorization.

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Benadryl (itch, insect bite, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	Pepto Bismol (diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	Tylenol(head/muscle aches/cramps)
<input type="checkbox"/>	<input type="checkbox"/>	Caladryl Lotion (poison oak)	<input type="checkbox"/>	<input type="checkbox"/>	Hydrocortisone Cream (itch/rash)	<input type="checkbox"/>	<input type="checkbox"/>	Cough Drops (cough)
<input type="checkbox"/>	<input type="checkbox"/>	Mylanta/Tums (upset stomach)	<input type="checkbox"/>	<input type="checkbox"/>	Polysporin Topical (minor cuts/burns)	<input type="checkbox"/>	<input type="checkbox"/>	Milk of Magnesia (constipation)
<input type="checkbox"/>	<input type="checkbox"/>	Robitussin (cough)	<input type="checkbox"/>	<input type="checkbox"/>	Betadine (disinfectant)	<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofin (pain reliever, fever reducer)
<input type="checkbox"/>	<input type="checkbox"/>	Claritin (allergies)	<input type="checkbox"/>	<input type="checkbox"/>	Non-Pseudo (sinus)	<input type="checkbox"/>	<input type="checkbox"/>	

Prescriptions for minors: (including Asthma/ADD/insulin/Epi-kit) any prescribed medicine or inhaler must be given the sponsoring organization for the camper's use under supervision. All medications must be sent in their original prescription container.

*Are you sending prescription or non prescription medication with your child? YES ☐ NO ☐

*If yes, please list and detail dosage information _____

→ please initial all boxes and sign below

_____ **Authorization for Medical treatment - (INITIALS REQUIRED OR CAMPER CANNOT BE TREATED)**

Initial

The undersigned do hereby authorize Managers of Pinecrest LLC and/or Church/group listed as agents for the undersigned, to consent to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care for myself or listed family member, which is deemed advisable by the rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medicine Practice Act or any dentist licensed under the dental Practice act, at a hospital or elsewhere. The above mentioned agent is authorized to make decisions concerning the health and general welfare of myself or listed family member. I give permission to the medical personnel selected by Pinecrest to provide routine health care, to administer medications; to release may records necessary for insurance purposes; and to provide or arrange necessary transportation for myself or listed family member for the duration of the stay at Pinecrest.

→ _____ **Physical Activity Release**

Initial

Pinecrest activities include, but are not limited to, *hiking, swimming, basketball, volleyball, soccer, archery, skateboard park, rock climbing wall, trampoline bungee, jumper, softball, batting cage, golf driving cage, zorh, water hamster ball.* There are risks of physical injury or harm from participating in any of the activities listed above. I voluntarily elect myself or family member listed to participate in the activities and assume the risks of injury or harm that could result from participation. On my own behalf and that of my personal representatives and heirs, I hereby release Pinecrest, its officers, employees, and agents and/or Church/group listed from all liability for any injury or harm to me or my family member listed from participating in said activities. I have read and understood this release.

Please list any activities that are highlighted and italicized above that you do not want to have camper participate in _____

→ _____ **SIGNATURE OF ADULT CAMPER OR PARENT / GUARDIAN OF CAMPER**

X _____ **DATE**

HEALTH SCREENING FORM

☐ Camper

Last Name	First Name	Middle Initial
Pinecrest		
Camp Name	Arrival Date	
July 29th	Aug 2nd	
Arrival Date	Departure Date	

No Yes Health History

☐ ☐ Have you been exposed to any known contagious disease?

If yes, please explain: _____

☐ ☐ Has a copy of the staff/camper immunization record been obtained?

No Yes

☐ ☐ Fever (oral temperature 100.4°F or above)

☐ ☐ Sore throat with fever

☐ ☐ Vomiting

☐ ☐ Diarrhea

☐ ☐ Severe itching of body or scalp

☐ ☐ Open draining sore on skin

☐ ☐ Severe headache

☐ ☐ Flu or flu like symptoms (fever, sore throat, cough, weakness, fatigue, sneezing, nausea, body aches)

☐ ☐ Rash

No Yes

☐ ☐ Attended camp

☐ ☐

☐ ☐

Signature of

parent/guardian

Date

Revised 01/2018