



PINNACLE SPORTS SUMMER DAY CAMP MEDICAL FORM
313 Medina Rd., Medina, OH, 44256, 330-239-0616, 330-239-0435 fax, www.pinnaclesports.org

CAMPER INFORMATION

CAMPERS NAME: _____
SS #: _____ DATE OF BIRTH: _____ AGE: _____
PARENT/GUARDIAN NAME: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ EMAIL: _____
Is the camper covered by medical insurance? _____ Company/Policy #: _____
CAMPER'S PHYSICIAN: _____ PHONE: _____
EMERGENCY CONTACTS (other than parent or guardian):
NAME: _____ HOME PHONE: _____ SECOND PHONE: _____
NAME: _____ HOME PHONE: _____ SECOND PHONE: _____

ALLERGIES

Is camper allergic to any medications? Please list med and reaction: _____
Is camper allergic to any food, drinks, plants, insects, etc.? Please list along with reaction: _____
Does camper require Epi-Pen for allergic reactions? _____ All campers MUST provide their own Epi-Pen.

IMMUNIZATION HISTORY

The American Camp Association requires records of all immunizations including the date of the last tetanus shot.
DTP/DTaP: _____ TB/Tetanus: _____
HIB: _____ Hep B: _____
Polio: _____ Varicella (chicken pox): _____
MMR: _____ Other: _____

MEDICATIONS

ALL camper medications, prescription and non-prescription, must be listed below and given to a PSSDC staff member. Medications must be in the original bottle with name, dose and frequency listed on the label. Medications will be kept in a locked room and distributed during lunch unless otherwise noted. PSSDC encourages campers and parents not to send medications to camp and to handle medication needs prior to coming to camp.

| <u>Medication</u> | <u>Dose</u> | <u>Time</u> |
|-------------------|-------------|-------------|
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MEDICAL HISTORY

List any recent illnesses and/or injuries in the past 45 days: _____
List any dietary restrictions: _____
History of asthma, triggers, inhalers – please explain: _____
History of epilepsy/seizures, frequency, length, medication/s – please explain: _____
Other medical issues (ADHD, behavior issues, eating disorder, fainting, heart defect, high blood pressure, etc.) - please explain: _____

I hereby give permission, consent and authorization to Pinnacle Sports and its employees to provide medical care to my child during PSSDC. I also give permission for the physician designated by Pinnacle Sports to treat my child for emergency medical issues while at PSSDC. In the event of hospitalization or acute emergency treatment, I give permission for the physician to treat my child in the event that I cannot be located immediately by telephone. PSSDC will make every effort to contact parents in case of an emergency.

PRINTED NAME OF PARENT/GUARDIAN: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____