SUMMER 2024 CAMPER HEALTH RECORD / MEDIA RELEASE

- 1. Parent(s) or guardian(s) MUST complete parts 1 4, 6, and 7
- 2. Parent(s) or guardian(s) may elect to:
 - Have parts 5A and 5C completed and signed by a doctor OR
 - Complete and sign parts 5A and 5B themselves

3. THIS FORM MUST BE PRESENTED TO THE NURSE UPON ARRIVAL AT CAMP

P.O. Box 74 / 400 Eaton Road, Fairview, PA 16415 Office: (814) 474-5001 | Fax: (814) 474-4818 Email: office@campnotredame.com

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PART 1 (Please print clear	·ly)					
Name of Camper:	• •			D.O.B.: /	1	Age:
Address:						
City:						
Parent / Guardian Email Addres	S:			Phone (2):_()	
Person to contact, if other tha	n listed above, if necessary v	vhile your ch	nild is at camp:			
Name:	Relation	nship:		Phone: ()		
PART 2 - IMMUNIZATION						
2A. I certify that my child is curre 2B. Please indicate the date of y 2C. Has your child received the	our child's most recent Tetanus			Yes: No Date: No Yes: No		
PART 3 - PARENTAL CON	ISENT					
I (we) authorize treatment for an non-prescription medications. If incurred for medication, treatme to administer any prescription or In case of emergency, preference Signature of Parent or Guardian	doctor or hospital service is need nt, injury or illness suffered by the non-prescription medications the of hospital and doctor:	eded, treatme he camper du that accompa	ent may be started. I (uring his/her stay at C any my (our) child to	we) agree to be responded by the composition was agreed to be responded by the composition with the composition and the composition was agreed to be responded by the composition with the composition and the composition was agreed to be responded by the composition with the composition and the composition was agreed to be responded by the composition with the composition and the composition was agreed to be responded by the composition will be composition and the composition and the composition was agreed to be responded by the composition was agreed by the composition and the composition was agreed by the composition and the composition are composition and the composition and the composition and the composition are composition and the composition and the composition are composition and composition are compo	ponsible for a (we) authoriz	ll expenses
PART 4 - FAMILY HEALTH	HINSURANCE INFORMAT	TION				
Name of Insurance Provider:						
				Phone:_()		
Address:	LD M					
Group Number:	I.D. NI	umber		Policy Holder		
PART 5A						
Does your child have any of the	following:		Please list any a	llergies.		
Dood year orma nave any or are	Yes (If yes, please explain)	No	i lodgo liot diriy d	norgioo.		
Diabetes	res (ii yes, piease expiairi)	110				
High Blood Pressure		- 				
Asthma / Reactive Airway						
Lung / Respiratory Problems						
Ear / Eyes / Nose Problems						
Muscle / Bone Issues						
Head Injury / Concussion			Doos vour shild	have an ani nan?	Vaar	No
Psychiatric / Emotional Difficulties			Does your child	have an epi pen?	res	NO
Blood Disorders		+	Does your child	have a rescue inhal	or? Voc	No:
Fainting Spells or Dizziness			Does your crillo	nave a rescue iniral	ci: 165	INO
Seizures						
Stomach / Digestive Disorders						
Sleep Walking						
Bed Wetting						
Other						
PART 5B - PARENT(S) W. In lieu of a physical examination participate in all Camp Notre Da in attesting to said good physica program. It is further agreed tha	by a licensed physician, (camp me activities, I (we) al condition, and therefore state t Camp Notre Dame is free of re	that the abovesponsibility	, as parent(s) ve-named camper is for any ill health cons	or guardian(s), do hable to participate in	ereby assum n all activities	e full responsibility of the Camp
health of the above-named cam	per prior to or at the time of his/	her arrival at	Camp Notre Dame.			
Signature of Parent or Guardian	:				Date:	
	:				Date:	

Allergic or sensitive to any food, medicine, or other substances:								
PART 6 - MEDICATIONS								
Please indicate any home medication	ns:							
MEDICATION		DOSE	B.FAST	LUNCH	DINNER	BEDTIME		
							**In order to provide your camper with the best possible	
							experience at camp, please try	
							to schedule medication times	
							around mealtimes, if possible. Thank you**	
							THAIR YOU	
Over the Counter Medications:				l	l			
The following medications will be available.	ilable through the	camp nurse	for your car	nper. Pleas	e check the	medications	vour child may be given during	
the week if needed. Medicine will be	•		•				,	
Acetaminophen (Tylenol)	Pepto Bism			AfterBite / Calamine		е	Sun Burn Cream	
Ibuprofen (Motrin)	Decongest	ant		Eye Dro			Antibiotic Ointment	
Benadryl / Allergy Anti-Diarrhea / Constipation	Antacid Cough Dro	nc		Swimme	er's Ear		Cold Medicine	
Anti-Dialmea / Constipation	Cough Dio	μs						
If sending	health form via	•	•		•		rse@campnotredame.com. ttending.	
PART 7 - 2024 MEDIA RELEAR This authorization form shall serve as	SE FORM parental permission	email, plean	ase includ	e the wee	k your ch	ild will be at	tending.	
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