CALVIN CREST OUTDOOR SCHOOL
MEDICAL & PARTICIPANT AUTHORIZATION FORM – Cabin Leader

Calvin Crest Conferences 45800 Calvin Crest Road Oakhurst, CA 93644
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The information on this form will be used to assist the director and staff. Your cooperation can help to insure a quality experience for all participants. Only staff will access this information and they will not share it with any other persons.

Cabin Leader LAST NAME: _____ FIRST NAME: _____
SEX ☐M ☐F BIRTH DATE: _____/_____/_____ AGE: _____ SCHOOL: _____
IN CASE OF AN EMERGENCY – please provide the name of a friend or relative:
Name: _____ Relationship to participant: _____
Daytime phone: (_____)_____ Evening phone: (_____)_____Cell: (_____)_____
PHYSICIAN(S): _____ Phone: (_____)_____
_____ Phone: (_____)_____
DENTIST/ORTHODONTIST: _____ Phone: (_____)_____
*****If under 18 please complete the following*****
PARENT/GUARDIAN 1: _____ Relationship: _____
Contact information:
Daytime phone: (_____)_____ Evening phone: (_____)_____Cell: (_____)_____
PARENT/GUARDIAN 2: _____ Relationship: _____
Contact information:
Daytime phone: (_____)_____ Evening phone: (_____)_____Cell: (_____)_____
THE FOLLOWING PERSON(S) IS/ARE *LEGALLY RESTRICTED* FROM SEEING THE PARTICIPANT:
Last Name: _____ First Name: _____ Relationship: _____
Last Name: _____ First Name: _____ Relationship: _____
THE FOLLOWING PERSON(S) IS/ARE THE ONLY ONES (BESIDES PARENTS) PERMITTED TO REMOVE THE PARTICIPANT FROM CALVIN CREST
Last Name: _____ First Name: _____ Relationship: _____
Last Name: _____ First Name: _____ Relationship: _____
Last Name: _____ First Name: _____ Relationship: _____

Health History Please attach a separate sheet to more fully explain any conditions/concerns that could affect participant's health during week of outdoor school. (Please list dates of most recent occurrence for all that apply.)

ALLERGIES		DISEASES		CONCERNS			
Hay Fever	_____	Chicken Pox	_____	Ear Infections	_____	Bleeding/Clot Disorder	_____
Plants	_____	Measles	_____	Mononucleosis	_____	Behavior Disorder	_____
Insects/Bees	_____	German measles	_____	Heart Disease/Defect	_____	Nervous Disorder	_____
Food	_____	Mumps	_____	Convulsions/Seizures	_____	ADD/ADHD	_____
Environmental	_____			Diabetes	_____	Hypertension	_____
Asthma	_____			Menstrual Problems	_____	Other	_____
(Chronic___ Seasonal___ Exercise Induced___)				Bronchitis	_____		
Other	_____						

Circle symptoms from last allergy attack (participants under 18 may take Benadryl for allergic reaction only with Doctor's written orders):
Shortness of Breath/Hives/Tightness in Chest/Sneezing, Runny Nose, Redness in Eyes
Explain all items checked above: _____
Disability, Chronic or Recurring Illness, or Medical Condition: _____
Insulin dependent diabetic? ☐Yes ☐No If yes, year diagnosed: _____ Participant is able to give his/her own injections? ☐Yes ☐No
Considered: Brittle 1 2 3 4 5 Stable (Circle number for degree of stability)
Is the participant able to calculate and change dosage to compensate for exercise, etc.? ☐Yes ☐No
History of Surgeries (include type and date): _____
History of Hospitalizations (include type and date): _____
History of Medication Allergies (please include medication and reaction): _____
_____
Dietary Modifications: _____ (We are not equipped to provide special diets.)
Activity Restrictions/Limitations: _____
Immunization History:
Last Tetanus Shot (Given around ages 5 & 14): (Mo & Yr) ____/____ Are all immunizations up to date? ☐ Yes ☐ No If no, please attach explanation.

Medications Is the participant currently taking any medications? ☐Yes ☐No
All prescriptions and over-the-counter medications, including vitamins and herbal products must be turned into the Outdoor School designated personnel upon arrival. (One inhaler for participants with asthma may be kept by them, if necessary.) Participants requiring injections should provide medications, syringes, and written instructions signed by the physician. This information will be kept confidential.
Please Note the Following: **All prescriptions medications, over-the-counter medications, vitamins, and herbal products brought without doctor's written orders CANNOT be given to participants under 18 at Calvin Crest**. Only medication properly prescribed for the participant will be given to him/her. All prescriptions medications, over-the-counter medications, vitamins, and herbal products MUST be in ORIGINAL containers with labels and dispensing instructions. DO NOT BRING a week's supply of medication in a baggy or medication box.

	Current Medication	**Dosage(mg)/Frequency**	**Type of Illness being treated**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

If more than 3 medications are being used, please attach a separate sheet. If this information changes before coming to Outdoor School, please report changes to Calvin Crest.

Other Information

To help us deal tactfully with individual needs, please let us know if participant: ☐Sleepwalks ☐ Has night or sleeping problems
☐ Has had recent changes/trauma which may impact emotional, physical or mental well-being
Explain items checked: _____
_____

Participant STATEMENTS, PERMISSION, AND RELEASE

By signing this form I give my informed consent to the First Aid personnel assigned by Calvin Crest who are certified in a minimum of CPR and First Aid by a nationally recognized provider in accordance with ACA standard HW-1 to provide basic First Aid and comfort measures through standardized camp treatment procedures. I understand that if I have greater health care needs than the First Aid personnel can provide within their individual certifications, licenses, and scopes of practice, it is my responsibility to make arrangements to meet those needs. I authorize Calvin Crest to arrange for or provide any necessary related transportation to the nearest medical facility for urgent or emergency medical treatment if indicated, and I do assume all responsibility for payment for such treatment. I hereby give permission to the physician selected by Calvin Crest to secure and administer any and all medical treatment deemed necessary, including hospitalization. This completed form may be photocopied for trips away from Calvin Crest properties.

I authorize the use of the following generic, over-the-counter medications as directed by the labels provided by the manufacturer and the Outdoor School designated personnel providing standard procedures: antibiotic ointment, hydrocortisone cream, burn cream, petroleum jelly, chapped skin/lip treatment, antiseptic skin and wound cleansers, analgesic balms and gels, with the exception of _____. I understand that these are stocked and dispensed by the First Aid personnel free of charge as needed.

I have requested Calvin Crest to allow myself to participate in any and all activities that may include but are not limited to those noted in the school presentation. As a condition of receiving this benefit, I do hereby agree to the following: I understand that my participation in these activities can expose me to dangers both from known and unanticipated risks. Acknowledging that such risks exist, I on behalf of myself and any other party who may have the right to assert any rights for or on behalf of me, do hereby forever release and discharge, indemnify and hold harmless Calvin Crest, its affiliates, officers, directors, agents, employees, insurers, successors in interest, attorneys, or any other person or persons associated with any or all of them who might be liable (the "Released Parties") from and against any and all claims, causes of action, actions, suits, demands, losses, damages, expenses, costs or liability (collectively, "Losses") arising from or in connection with my participation in Calvin Crest Outdoor School and its activities, including Losses arising from the negligence of any of the Released Parties, whether such Losses arise in connection with bodily injury (including death), property damage or otherwise (collectively, the "Released Claims"). The Released Claims include Losses arising out of any condition of the premises at which the camp activities are held or the conduct of any person in connection with the preparation for, supervision of, or conduct of any activity, whether planned or unplanned.

I give permission for the use of images and audio or video recordings including myself or articles written by me to be used in publicity including Calvin Crest website, internet sites, newsletter, or brochure promoting or reporting Calvin Crest.

I further understand and acknowledge that I make this release in full accord and satisfaction of and in compromise of any and all Released Claims. I represent and acknowledge that I have read and understand this form and the release granted above and warrant that all statements made herein are true to the best of my knowledge.

- I will be responsible for notifying Calvin Crest of any new medication information between now and start of Outdoor School.
- I realize that if my medications change between now and the date of Outdoor School, it is my responsibility to report such to Calvin Crest.
- I understand that Calvin Crest is located in a remote mountain region and that emergency care, even by ambulance, can take as long as 90 minutes. I have no current condition that would warrant closer emergency medical care.
- If medication is involved, I will take responsibility for reporting at scheduled times for this purpose.
- I understand that Calvin Crest assumes no responsibility for participants who leave Calvin Crest grounds for any reason other than programmed activities.

I have read and understand this entire form and by signing below agree to the terms herein.

Signature of Participant _____ **Date** _____

Signature of Parent or Legal Guardian **(if participant is under 18)** _____ **Date** _____

To NOT grant consent for treatment

I do not give my consent for emergency medical treatment. In the event of any injury or illness requiring emergency treatment, I wish Outdoor School personnel to take no action or to (Instructions to be followed) _____
_____

Signature of Participant: _____ Date: _____
Printed name: _____ Phone: (_____)_____
Address: _____
Signature of Parent or Legal Guardian (if participant is under 18): _____ Date: _____
Printed name: _____ Phone: (_____)_____
Address: _____

Insurance Information Is the participant covered by medical/hospitalization insurance? ☐ Yes ☐ No
If yes, name of Insurance Company: _____ Primary Policy Holder Name: _____
Policy Holder ID: _____ Policy Holder Date of Birth: ____/____/____ Relationship to participant: _____
Policy Holder Address: _____ Phone: (_____)_____
Participant Insurance ID: _____ Student Date of Birth: _____/_____/_____
If needed for treatment, please provide the pre-authorization phone number: _____
Please supply a copy of the participant's health insurance card – front & back – cut out & attach with tape. No staples, please.

FRONT
of
Medical Insurance Card

BACK
of
Medical Insurance Card