JCC CAMP BY THE SEA MEDICAL FORM 2015

CAMPER INFORMATION

(This side is to be filled out by parent/guardian):

Camper's Full Name ___________________________________ Gender ☐ Male ☐ Female

Date of Birth ___________________ Grade entering Fall of 2015 _________

Parent/Guardian completing this form ________________________________

Address ____

City ___________________________ State _________ Zip __________

Camper lives with ☐ Both Parents ☐ Mother ☐ Father ☐ Other________________

INSURANCE INFORMATION:

Carrier/Plan Name ____________________________________ Group # _______________

Policy # _________________________ Name of Insured _____________________________

EMERGENCY CONTACTS (Please indicate two people to contact in the advent both parents are unreachable)

Name ________________________________ Relationship _____________________

Home Phone _________________________ Cell Phone ________________________

Name ________________________________ Relationship _____________________

Home Phone _________________________ Cell Phone ________________________

Is your child or the family receiving any special help with emotional or behavior at school or home (psychiatrist, social worker, counselor, etc.)? Please explain

____

Does your child have an IEP or 504 Plan? Please explain

____

Has camper been identified as needing support or supplemental services during the school year in these areas?

☐ Academic ☐ Personal/Social ☐ Language ☐ O.T. ☐ Health Emotional ☐ Behavioral

Please describe the nature of these services

____

PARENT AUTHORIZATION:

The information and health history provided on this form is accurate to the best of my knowledge. The camp and camp employees shall be held harmless for any omission or incorrect medical information provided. The person herein named has permission to engage in all camp activities as noted. I hereby give permission to the camp to administer prescribed medications and seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician, medical provider selected by the camp to secure and administer treatment, hospitalize, order injection, anesthesia or surgery for my child as named above. This completed form may be photocopied for trips outside of camp.

___________________________ ___________________________ ___________

Signature of Parent/Guardian Printed Name Date

MEDICAL EXAMINATION

(This side is to be completed and signed by a Licensed Physician)

Date of Examination/Visit ______________ Height ______ Weight ______ Blood Pressure _______

Code: S = Satisfactory X = Not satisfactory (please explain) O = Not examined

Eyes ________ Ears _________ Nose _______ Throat __________ Teeth __________ Heart _________

Lungs _________ Extremities ___________ Posture ___________ Skin ____________

For females—Has this person menstruated _________? If not, has she been told about it ? ____________

Known allergies & reactions____

____

This applicant is under the care of a physician for the following conditions: _________________________

____

Current Treatment & Medications: ____

____

Recommendations & Restrictions while at Camp: ____

____

HEALTH HISTORY

- ☐ Vision Problems
- ☐ Hearing Deficiency
- ☐ Frequent Headaches
- ☐ Asthma
- ☐ Diabetes
- ☐ ADD
- ☐ ADHD
- ☐ Skin Problems
- ☐ Seizures or epileptic symptoms
- ☐ Heart Problem (murmur, etc)
- ☐ Kidney or U.T. problems
- ☐ Eating Disorder
- ☐ Behavior/emotional problems
- ☐ Physical Limitations
- ☐ Stomach & Intestinal problem
- ☐ Operations or Recent injury
- ☐ Frequent Headaches
- ☐ Other __________________

If you checked a box above, please explain ___________________

____

IMMUNIZATION HISTORY

This is a record of DATES of basic immunizations and booster doses.

DPT ___________________________

Polio IPV _________________________

MMR ___________________________

HIB _____________________________

Tetanus _________________________

Hepatitis B _______________________

Varicella _________________________

Influenza_________________________

Pneumococcal Conj. ________________

Rotateq __________________________

Please attach additional sheet if necessary

I have examined this individual and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted above. I have been this applicant's physician for __________ years

Examining Physician (Signature) ____ Date _____________

Address ____ Phone __________________________