

JCC CAMP BY THE SEA MEDICAL FORM 2017

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 2017 _____

Mom's cell _____ Dad's Cell _____

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 _____