

# JCC OF SYRACUSE AFTER SCHOOL PROGRAM 2009-2010 EMERGENCY INFORMATION DOCUMENT

With information taken from the NYSOCFS Day Care Registration form

**IMPORTANT:** Please read and sign where appropriate on both sides of this form.

The JCC must have a current *Emergency Information Document* on file for each participant in its programs. Please complete the following form for the current year as part of the After-School Program, HPER Classes, and/or Vacation Camps.

CHILD'S INFORMATION (One Form per Child)		
Last Name	First Name	Age
Address		M / F
City	State	Zip
Phone	Birthdate	
Name of Person Applying for Child		Relationship to Child

MEDICAL INFORMATION
Does your child have allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes
Please list all known:
Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs, please list them here and discuss them with the Director.
_____
_____
_____
_____

PHYSICIAN	
Child's Primary Care Physician	Phone number
Address	City, St

DENTIST	
Child's Dentist	Phone number
Address	City, St

PREFERRED MEDICAL FACILITY	
Name of Preferred Care Center/Hospital	Phone number
Address	City, St

EMERGENCY CONTACT INFORMATION (Other than numbers above) MUST BE LOCAL			
Name	Phone #1	Phone #2	Relationship
Name	Phone #1	Phone #2	Relationship
Name	Phone #1	Phone #2	Relationship

**JEWISH COMMUNITY CENTER OF SYRACUSE ■ 5655 THOMPSON ROAD ■ DEWITT, NEW YORK 13214  
315-445-2360 ■ www.jccsyr.org**

# JCC OF SYRACUSE AFTER SCHOOL PROGRAM 2009-10 EMERGENCY INFORMATION DOCUMENT

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<b>AGREEMENTS</b>	
I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.	Initial _____
I have provided information on my child's special needs (Allergies, Diet, Disabilities, and/or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency.	Initial _____
I agree to review and update this information whenever a change occurs and at least once every six months.	Initial _____
<p>Lead Poisoning is a potential health hazard to children. Because this is such a serious problem, the State of New York now recommends that ALL children under the age of six years old be screened for Lead Poisoning. Like all other regulated Child Care Providers in New York State, the JCC is required by law to request that your child be screened for Lead Poisoning. If your child has been screened, I need to have verification on file. If not, please review the attached information and plan to have a screening done as soon as possible. Further information regarding Lead Poisoning is available through your health care provider or the Onondaga County Department of Health Lead Poison Control Center at 435-3271. Remember, our goal is to keep your children healthy! This law is NOT intended to keep your children out of Day Care, but to take that extra step toward ensuring GOOD HEALTH.</p> <p>I have received from the Jewish Community Center of Syracuse's After-School Program information regarding Lead Poisoning.</p> <p>_____ Date _____</p>	
Signature of Parent	Date

<b>EMERGENCY AUTHORIZATION</b>	
I hereby appoint the appropriate JCC staff members to act on my behalf in authorizing unexpected medical, dental, or surgical care and/or hospitalization for the below named minor during the period of _____ (start date) through June 30, 2009 in the event of my unavailability.	
Name of Minor	Age
Allergies / Special Conditions	Date of Birth
Signature of Parent/Guardian	Date
Signature of Witness	Date

<b>HEALTH CONCERNS</b>

<b>INSURANCE</b>	
Do you carry family medical/hospital insurance?	
Carrier	Policy or Group #

***This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical or hospitalization may be required.***