

JCC OF SYRACUSE

2010 CAMP RISHON HEALTH & EXAMINATION FORM

CHILD'S INFORMATION (One Form per Child)

Last Name	First Name	Age	Birthdate
Height	Weight	M / F	Grade '21. 22

PARENT / GUARDIAN INFORMATION

Parent #1 / Guardian Last Name		First Name	
Work Phone	Home Phone	Cell Phone	
Address	City	State	

Parent #2 / Guardian Last Name		First Name	
Work Phone	Home Phone	Cell Phone	
Address	City	State	

IF NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY (LOCAL ONLY):

Name		Relationship
Work Phone	Home Phone	Cell Phone

MEDICAL CONTACTS

Physician	Phone	Address
Dentist	Phone	Address
Do you carry medical insurance? Y / N	Carrier	Policy/Group #

HEALTH HISTORY (Check All That Apply)

Health	Diseases	Approximate Dates	Diseases	Approximate Dates
<input type="checkbox"/> Heart Defect Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Seizures	<input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps	<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C	_____ _____ _____ _____ _____ _____ _____ _____
Other diseases or details of above:				

ALLERGIES (List All Known)

CURRENT MEDICATIONS (List All Known)

MEDICAL AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, and treatment for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. This form may be photocopied for use out of camp.

Signature of Parent	Date
Signature of Witness	Date

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RESTRICTIONS

The following apply to this individual:

HEALTH CONCERNS

Please list any special health conditions/concerns which may help us better serve your child while enrolled in camp.

T O B E C O M P L E T E D B Y A L I C E N S E D P H Y S I C I A N

I have examined _____ within the past two years Date Examined _____

In my opinion, the above's condition _____ does / _____ does not impact his/her participation in summer camp.

The applicant is under the care of a physician for the following condition(s):

Licensed Physician's Signature _____ Date _____

Address _____ Phone _____

IMMUNIZATION HISTORY

Vaccines	Year of Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping cough) Tetanus		
Tetanus Diphtheria		
Tetanus		
Polio		
Haemophilus influenza B		
Measles (hard and red measles, Rubella)		
Mumps		
Rubella (German and 3-a-day Measles)		
Hepatitis B		
Varicella (chicken pox)		
Tuberculin Test		