SJCC **SUMMER CAMP'15**

# HEALTH HISTORY AND EXAMINATION FORM

For Sabes JCC Summer Programs and Staff

For Office Use Only:
- ☐ Olami
- ☐ Summer Quest
- ☐ SIT
- ☐ Extended Care

**Both sides of this form must be completed.**

**(This side to be filled in by parents/guardian of minors.)**

Name _____ Birthdate _____ Sex _____ Age _____

Parent or Guardian _____

Home Address _____ Phone (  ) _____

Business Address _____ Phone (  ) _____

## HEALTH HISTORY

(Check. Give Approximate Dates)

_____Frequent Ear Infections
_____Heart Defect/Disease
_____Convulsions
_____Diabetes
_____Bleeding/Clotting

**DISORDERS**

_____Hypertension
_____Mononucleosis
_____Epilepsy

**DISEASES**

_____Chicken Pox
_____Measles
_____German Measles
_____Mumps

**ALLERGIES** (Dates not needed)

_____Hay Fever
_____Ivy Poisoning, etc.
_____Insect Stings
_____Penicillin
_____Other Drugs
_____Asthma
_____Other (specify)

Second Parent or Guardian or Emergency Contact _____

Home Address _____ Phone (  ) _____

Business Address _____ Phone (  ) _____

Operations or serious injuries (include dates) _____

Chronic or recurring illness or medical conditions _____

Dietary restrictions _____

Current Medications (send with instructions) _____

Other Diseases _____

Name of dentist/orthodontist _____ Phone (  ) _____

Name of family physician _____ Phone (  ) _____

> Do you carry family medical/hospital insurance? ◯ Yes ◯ No

If so, indicate Carrier _____ Policy or Group # _____

Any other health related information for personnel _____

**IMPORTANT—SIGNATURE REQUIRED FOR ATTENDANCE.**

This health history is correct so far as I know, and the person herein described has permission to engage in all activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips.

**SIGNATURE:** _____ **DATE:** _____

## Both sides of this form must be completed. (THIS SIDE TO BE COMPLETED BY PHYSICIAN)

### IMMUNIZATION HISTORY

| VACCINES | YR OF BASIC IMMUN (MO/DY/YR) | YR OF LAST BOOSTER (MO/DY/YR) |
|---|---|---|
| *Diptheria<br>*Pertussis (Whooping Cough) > DPT<br>*Tetanus | 1<br>2<br>3 | 1<br>2 |
| Tetanus | | |
| *Polio OPV/IPV | | |
| *Measles (hard measles, red measles, Rubella) | | |
| *Mumps | | |
| *Rubella (German measles, 3-Day measles) | | |
| Other | | |
| Tuberculin test give _____ most recent | | |
| *Haemophilus influenza b (HIB) | | |
| Hepatitis B | | |

## HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN

> I I have examined this child within the past 18 months. Date examined_____

> This child's condition o does o does not preclude his/her participation in an active program.

Height Weight Blood Pressure

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

Current treatment (include current medications)

Explanation of any reported loss of consciousness, convulsion or concussion

> Does the applicant have epilepsy? ◯ Yes ◯ No > Does the applicant have diabetes? ◯ Yes ◯ No

## RECOMMENDATIONS AND RESTRICTIONS

Any treatment to be continued

Any medication to be administered (specific dosage)

Any medically prescribed meal plan or dietary restrictions

Any allergies (food, drugs, plants, insects, etc.)

Activities to be encouraged or limited

Additional Health Information

Licensed Physician's Signature

Address Phone ( )

Date of form completion *By