SJCC SUMMER CAMP'19

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 ( )

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? o Yes o 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	M/D/Y OF BASIC IMMUN	M/D/Y OF LAST BOOSTER
*Diptheria *Pertussis (Whooping Cough) > DPT *Tetanus	1 2 3	1 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? o Yes o No > Does the applicant have diabetes? o Yes o 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