THE JCC OF SYRACUSE 2017 CAMP RISHON HEALTH AND EXAMINATION FORM

Camper:	Grade Entering in Fall:

Camper Information

Birth date: ___/___/_____ Age: _____ Gender: M / F

Nickname:_____ Height : _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Information

Parent #1 Name: _____ (H) Phone: _____ (W) Phone: _____ (Cell): _____

E-mail: _____ Best # To Call: H W C

Parent #2 Name: _____ (H) Phone: _____ (W) Phone: _____ (Cell): _____

E-mail: _____ Best # To Call: H W C

Emergency Contact: _____ (H) Phone: _____ (W) Phone: _____ (Cell): _____

Emergency Contact: _____ (H) Phone: _____ (W) Phone: _____ (Cell): _____

Medical Contacts

Physician Name: _____ Phone _____ Address: _____

Dentist Name _____ Phone _____ Address: _____

Do You Have Medical Insurance (Y/N) ____ Name of Carrier _____Policy Group Number: _____

Health History (please check where appropriate and explain "YES" answers)

	YES	NO		YES	NO
Vision Problems (i.e.: wears glasses etc.)	☐	☐	Kidney and/ or urinary track problems	☐	☐
Hearing Deficiency	☐	☐	Heart problems (i.e.: murmur etc.)	☐	☐
Frequent headaches	☐	☐	Asthma	☐	☐
Seizures or other epileptic symptoms	☐	☐	Diabetes	☐	☐
Recent or reoccurring serious injuries	☐	☐	Stomach and/or intestinal problems	☐	☐
Physical limitations	☐	☐	Special dietary consideration	☐	☐
Behavior/emotional problems or fears	☐	☐	ADD/ ADHD	☐	☐
Hepatitis	☐	☐	Measles	☐	☐
MumpsHypertension	☐	☐	Clotting Disorder	☐	☐
Mononucleosis	☐	☐	Chicken Pox	☐	☐
	☐	☐	Other	☐	☐

Please explain all "YES" answers: _____

Medication

Are there any medications to be administered during normal camp day (be specific, must include a doctor's authorization with directions):

Yes/No List: _____

Are there List any medication taken during the school year that are **not** being taken during the summer:

Yes/No List: _____

Allergies (No known allergies please check here) ☐

Food and Allergies LIST ALL	Describe Reaction & Management
Medication LIST ALL	**Describe Reaction & Management**
Environmental LIST ALL	**Describe Reaction & Management**

Camper Questionnaire

Is your child or the family receiving any special help with emotional concerns or behavior at school or home (psychiatrist, counselor, social worker etc.)?

Yes/No Describe:_____

Has your child been identified as needing support or supplemental services, during the school year, in any of the following areas?

____ Academic ____ Personal/social ____ Language ____ Speech ____ OT ____ Health

____ Emotional (i.e.- anxiety, fears) ____ Behavioral (i.e.- ADD/ADHD, impulsivity) _____ none

Please describe the nature of these services: _____

Does your child have an IEP or 504 plan? **Yes/No**

Are there any restrictions that apply while at camp? **Yes/No**

Desribe:_____

Is there anything else you would like us to know about your child that will aide us in helping him/her to have a fun, well adjusted summer?

_____

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. Please initial: _____

I hereby give permission to the medical personnel selected by the Camp 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 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 or guardian: _____ Date: _____

Signature of witness: _____ Date: _____

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Physical Exam To Be Completed by a Licensed Physician

Name of Physician: _____ Phone Number: _____

I have examined _____within the past two years. Date examined: _____
In my opinion the above's condition does _____/does not _____prevent his/her participation in summer camp.

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

_____

Immunizations:

Please complete the box below or attach a copy of your child's immunization records.
Health forms cannot be accepted without this infomration.

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		

JCC of Syracuse Camp Rishon
5655 Thompson Road
DeWitt, New York 13214
Fax: (315) 449-4539