

**JEWISH COMMUNITY CENTER
MEDICAL FORM**

NAME _____ BIRTHDATE _____

PARENT/GUARDIAN _____

ADDRESS _____ PH _____

SECOND EMERGENCY CONTACT:

PARENT/GUARDIAN _____

HOME ADDRESS _____ PH: _____

HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN

Height _____ Weight _____ Gender _____ Wears Glasses _____

IMMUNIZATION DATES:

DTP/DtaP	Date _____	Date _____	Date _____	Date _____	Date _____
POLIO	Date _____	Date _____	Date _____	Date _____	Date _____
HIB	Date _____	Date _____	Date _____	Date _____	
HEP B	Date _____	Date _____	Date _____		
MMR	Date _____	Date _____			
VARICELLA	Date _____	Date _____			
TETANUS	_____				

The applicant is under the care of a physician for the following conditions: _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does the applicant have epilepsy? _____ Does the applicant have diabetes? _____

Contagious diseases applicant has had _____

Recommendations & restrictions while attending camp? _____ Asthma _____

Any medications to be administered (specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

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

Additional health information _____

I have examined the above applicant and found him/her to be admitted and to participate in all JCC activities.

Licensed Physician/s Signature _____

Address _____ Phone _____

Date of form completion _____ *By _____

AUTHORIZATION FOR EMERGENCY AND/OR TREATMENT

The authorization granted will be used when absolutely necessary and after every attempt has been made to contact parent. In case of emergency, I hereby authorize the doctor to which my child is brought (and whomever they designate as their assistants) to perform any emergency procedure or operation, to give treatment and to administer anesthetic to my while participating in JCC Activities.

Signed _____ **Date** _____ **Relationship to camper** _____

Insurance Number _____

Persons Authorized to Pick Child Up: _____

Emergency Phone Numbers: Parent 1 Cell: _____ Parent 2 Cell: _____