

# SUMMER CAMP'10

## 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	Street & Number		City State Zip Code
Business	Street & Number		City State Zip Code
Phone ( )			
Second Parent or Guardian or Emergency Contact	Street & Number		City State Zip Code
Home Address	Street & Number		City State Zip Code
Business	Street & Number		City State Zip Code
Phone ( )			
Street & Number	City		State Zip Code
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)

Operations or serious injuries (include dates)

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Chronic or recurring illness or medical conditions

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Dietary restrictions

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Current Medications (send with instructions)

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Other Diseases

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Name of dentist/orthodontist Phone ( )

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Name of family physician Phone ( )

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

If so, indicate Carrier Policy or Group #

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Any other health related information for personnel

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### 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	YEAR OF BASIC IMMUN (MONTH/DY/YR)	YEAR OF LAST BOOSTER (MONTH/DY/YR)
*Diphtheria	1	1
*Pertussis (Whooping Cough) > DPT	2	2
*Tetanus	3	
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 have examined this child within the past 18 months. Date examined \_\_\_\_\_

> This child's condition  does  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 ( ) \_\_\_\_\_

Street & Number City State Zip Code

Date of form completion \_\_\_\_\_ \*By \_\_\_\_\_

\*Initial if completed by nurse or physician's assistant