



James and Rachel Levinson Summer Day Camp Camper Information Form

Session I Session II Male Female Age (June 2010) _____ Grade (Fall 2010): _____

Camper Name _____ Birthday _____ / _____ / _____

Home Phone _____ Address _____ City _____ State _____ Zip _____

Parent/Guardian Name _____ Cell# _____ Business# _____

Parent/Guardian Name _____ Cell# _____ Business# _____

IF PARENT IS UNAVAILABLE IN AN EMERGENCY PLEASE NOTIFY:

Name _____ Cell# _____ Business# _____

Relationship _____ Address _____ City _____ State _____ Zip _____

Grouping:

Please list three (3) friends you would like your camper to be grouped with. Every effort will be made to accommodate your request.

1. _____ 2. _____ 3. _____

Dietary Restrictions:

The camper eats a regular diet The camper has special food needs

Please list any dietary restrictions your camper may have:

Allergies:

The camper is allergic to Food Medicine The environment (insect stings, hay fever, etc.) Other No known allergies

Please describe any allergies your camper may have and their reaction:

Please return this form by May 15, 2010.

*All forms can be returned to: Jewish Community Center Attn: Jayme Vertullo •5738 Forbes Avenue • Pittsburgh, PA 15217.
All campers must have a completed form on file before camp begins. No camper will be permitted without a completed form.*



James and Rachel Levinson Summer Day Camp Camper Information Form (Cont.)

Session I Session II Male Female Age (June 2010) _____ Grade (Fall 2010): _____

Camper Name: _____ Birthday: _____ / _____ / _____

Physical Restrictions:

I have reviewed the provided Parent Handbook and understand the activities of this camp and feel that my camper can participate **without** restrictions.

I have reviewed the provided Parent Handbook and understand the activities of this camp and feel that my camper can participate **with** the following restrictions.

Please list any physical restrictions your camper may have:

Previous camp experience:

Please tell us about your camper's previous camp experiences to help ensure that he/she has the most successful camp experience. Please also list his/her fears, dislikes, likes, and any other pertinent information:

Please read carefully and sign:

Campers should refrain from bringing the following to camp: toys, electronics, cell phones, and all personal sports equipment other than goggles used for swimming. Any behavior that endangers one's health or safety, or that of any other camper or staff member may be cause for immediate removal of the camper from the program. Possession and/or usage of any drugs, alcohol, tobacco product, or weapons may also result in the immediate removal of the camper from the program.

Parent/Guardian Signature _____ Date _____

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James and Rachel Levinson Summer Day Camp Medical Information Form

Session I Session II Male Female Age (June 2010): _____ Grade (Fall 2010): _____

Camper Name: _____ Birthday: ____/____/____

Home Phone: _____ Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Cell# _____ Business# _____

Parent/Guardian Name: _____ Cell# _____ Business# _____

IF PARENT IS UNAVAILABLE IN AN EMERGENCY PLEASE NOTIFY:

Name: _____ Cell# _____ Business# _____

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

Please indicate if the camper has:

- | | | | |
|--|--|---|--|
| 1. Had any recent injury or infection? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had problems with diarrhea/constipation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Chronic recurring illness/condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Any skin problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had asthma/wheezing/shortness of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had an eating disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Ever had emotional difficulty for which professional help was sought? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Ever had chest pain during/after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Had frequent headaches/Migraines? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Ever had high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Wear glasses, contacts, protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Any bleeding or clotting disorders? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Hepatitis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Had Measles? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Had Mononucleosis in the last 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Had Chicken Pox? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Had Mumps? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 12. Had Rheumatic or Scarlet Fever? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Allergies:

- Hay Fever Ivy Poisoning Asthma Insect Stings Penicillin Tree Nuts Peanuts Strawberries Gluten/Wheat
- Other Drugs _____ Other Food _____ Other _____

If you answered yes to any of the above questions, please explain in detail:

Immunizations: (Please give approximate dates)

- Tetanus _____ DTP _____ DT _____ MMR _____ IPV _____ HIB _____
- PCV _____ Hepatitis A _____ Hepatitis B _____ Varicella _____ MCV4 _____

If your camper has not been fully immunized, please sign the following statement:

I understand and accept the risks to my child from not being fully immunized.

Parent/Guardian Signature: _____ Date: _____

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James and Rachel Levinson Summer Day Camp Medical Information Form (Cont.)

Session I Session II Male Female Age (June 2010): _____ Grade (Fall 2010): _____

Camper Name: _____ Birthday: ____/____/____

Medical Insurance:

This camper is covered by family medical/hospital insurance: Yes No

Insurance Company: _____ Policy #: _____

Primary Member/Subscriber: _____ Insurance Co. Phone #: _____

Please note that if the camper does not have medical coverage, medical care will still be provided in an emergency. The camper's family will be responsible for all incurred medical costs.

Physician Information:

Date of last physical exam: ____/____/____ Physician Name: _____

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

Current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp:

Medication:

Over-the-Counter Medication:

I give my camper permission to be administered the following over-the-counter medication on an as-needed basis. *(Please check all that apply)*

Adult Tylenol Children's Tylenol Oral Benadryl Spray Benadryl Adult Motrin Children's Motrin Antacid

Bactine Hydrogen Peroxide Throat Lozenges Cough Drops Topical Anesthetic Anti-Itching Lotion

Prescription Medication:

This camper will not take any medication while at camp This camper takes the following medication while at camp:

Medication	Date Started	Reason for Taking	When it is Given	Dosage

All medication must be in its original container. Pharmacy labels are required for all prescription medications. Non-prescription medications should be sent in original containers with the camper's name clearly written on it.

Authorization for Medical Treatment:

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment and necessary related transportation for my child in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization for the person named above. If I do not give permission for camp/medical personnel to treat my child, I understand that I must contact the camp director and provide specific instructions for how to proceed in an emergency.

I understand that all medication may only be administered to campers upon written order of a physician. This health history is correct so far as I know and the person herein described has permission to engage in all camp activities except as noted. The completed form may be photocopied for trips out of camp.

Yes, I give camp/medical personnel permission to medically treat my child.

No, I do not give camp/medical professionals permission to medically treat my child. *(Please contact camp director with specific instructions.)*

Parent Signature: _____ Date: _____

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