



JCC After School Programs 2011-2012 Emergency Information Form

Clubhouse Teen Center

Male Female Age: _____ Grade (Fall 2011): _____ Birthday: ____/____/____

Child Name: _____ 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# _____

Release Information:

Please list persons, other than the parents listed above, to who your child may be released:

Name: _____ Relationship: _____ Phone: _____

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Name: _____ Relationship: _____ Phone: _____

Please indicate if the child 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:

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: _____



JCC After School Programs Emergency Information Form (Cont.)

Male Female Age: _____ Grade (Fall 2011): _____ Birthday: ____/____/____
Child Name: _____ Home Phone: _____

Medical Insurance:

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

Insurance Company: _____ Policy #: _____

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

Please note that if the child does not have medical coverage, medical care will still be provided in an emergency. The child'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 child 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 Antacid Bactine Hydrogen Peroxide Cough Drops Anti-Itching Lotion

Prescription Medication:

This child will not take any medication This child takes the following medication:

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 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 director to secure and administer treatment, including hospitalization for the person named above. If I do not give permission for 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 my child 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 activities except as noted. The completed form may be photocopied for trips out.

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

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

Parent Signature: _____ Date: _____

Parental Consent for Trips

I hereby give my child permission to participate in the following activities:

Swimming Club (Tuesdays and Fridays) Trips to the Carnegie Library, Forbes Avenue Trips to Davis Park, Hobart Street

Parent/Guardian Signature: _____ Date: ____/____/____