



MEDICAL FORM

Jewish Community Center of Atlantic County, 501 North Jerome Avenue, Margate, NJ 08402 (609) 822-1167

Name: _____ Gender M F DOB _____ Age at Camp _____

Summer Address _____ City _____ Zip _____

Summer Phone _____ Social Security Number _____

Parent/Guardian _____ Cell Phone _____

Place of Business _____ Work Phone _____

Second Parent/Guardian _____ Cell Phone _____

Place of Business _____ Work Phone _____

If not available in an emergency, notify:

Name _____ Relationship _____ Home Phone _____

Cell phone _____ Work Phone _____ Other _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____ Policy # _____

Name of insured _____ Claims/Phone Authorization # _____

HEALTH HISTORY

- | <u>Allergies</u> | <u>Diseases</u> | <u>Conditions</u> | |
|--|---|--|---|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Ivy Poisoning | <input type="checkbox"/> Measles | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Bee Stings | <input type="checkbox"/> German Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Mumps | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Heart Defect | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Bleeding Clotting | <input type="checkbox"/> Recent Injury |
| _____ | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Wears Glasses |

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition: _____

Other Diseases: _____

Dietary Restrictions: _____

Current Medications: _____

Activities to be restricted: _____

Physician: _____ Phone: _____

PARENT'S AUTHORIZATION

This health history is correct and complete to my knowledge. This person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician/health care provider selected by the camp to secure and administer treatment, order injection, anesthesia, surgery or hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian or Adult Staff Member _____

Printed Name _____

Date _____

IMMUNIZATION HISTORY

This is a record of DATES of basic immunizations and booster doses (MM/YY)

- DPT _____
- Polio OPV (Sabin) _____
- MMR _____
 - or Measles _____
 - or Mumps _____
 - or Rubella _____
- Smallpox _____
- Tetanus Booster _____
- Hepatitis B _____
- TB Mantoux Test – date of last test _____ Result Positive Negative
- Varivax (Chicken Pox) _____
- Other _____

MEDICAL EXAMINATION

To be completed and signed by a licensed physician.

Height _____ Weight _____ Blood Pressure _____

CODE: S = Satisfactory X = Not Satisfactory (explain) O = Not Examined

Eyes _____ Glasses _____ Contacts _____
 Ears _____ Nose _____ Throat _____ Teeth _____
 Heart _____ Lung _____ Extremities _____
 Posture (Spine) _____ Skin _____ Hernia _____

For female – Has this person menstruated? _____ If not, has she been told about it? _____

Known Allergies _____
 General Appraisal _____
 Special Considerations _____

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

Current Treatment/Medications:

Recommendations and Restrictions while at camp:

I have examined this individual and have reviewed his/her health history. It is in my opinion that he/she is physically able to engage in camp activities except as noted above. I have been this applicants physician for _____ years.

Examining Physician _____ Print name _____ Date _____
 Address _____ Phone _____

FOR CAMP USE ONLY: Date Received _____ Date Reviewed _____ Medication Received _____ Doctors Orders _____