JCC BERNIE CAMP/AFTERSCHOOL HEALTH ASSESSMENT FORM

Child's Name _____ **DOB**_____ **Sex**___ **Age**___
First Last Mo/Day/Yr

Address _____

Phone _____

ILLNESSES OR MEDICAL CONDITIONS: Does your child have any of the following:

	NO	YES		NO	YES
Asthma	☐	☐	Visual Impairment	☐	☐
Diabetes	☐	☐	Developmental Delays	☐	☐
Seizures	☐	☐	Physical Impairment	☐	☐
Heart Problems	☐	☐	Behavioral/Emotional Problems	☐	☐
Hearing Impairment	☐	☐	Other:_____		

Does your child have any special needs or known allergies? (if yes, please describe)_____

_____

_____

Please include any additional health information or instructions you feel we need to be aware of:___

_____

_____

Name of Child's Physician:_____ **Phone:**_____

*****NOTE: Your child's registration is not complete until immunization records have been submitted to the Youth & Teen Department.** ***Failure to submit these records may result in exclusion from the program until records are received.***

RECOMMENDATIONS AND RESTICTIONS

Special Diet_____

Swimming and Diving_____Strenuous Activity_____

*Special Medication _____

**Medication Release Form must be completed if medications are to be administered at Camp/Afterschool program (no medication will be given unless specified by physician and in its original container).*

IMPORTANT: Please notify the Camp/Afterschool administrators if this participant is exposed to any communicable diseases during the three weeks prior to Camp/Afterschool participation or during attendance.

PARENT AUTHORIZATION:

In the event of an emergency which affects the health of the camper, I the undersigned, do hereby authorize officials of the Jewish Community Center to contact directly the named physician to render such treatment as may be deemed necessary in an emergency, for the health of the child. In the event that neither parent nor guardian nor doctor nor any of these people can be reached, I hereby give the personnel of the Jewish Community Center of Salt Lake City permission to make arrangements for emergency medical attention, to transport the student to an accredited facility for diagnosis and treatment and to authorize the administration of medication as necessary.

I request and authorize physicians, dentists and staff of the accredited medical facility to perform any diagnostic procedures, treatment procedures, x-ray treatments and administration of anesthetics as may be necessary in the diagnosis and treatment of above minor student. I understand that I have not been given a guarantee as to the results of examination or treatment. I agree to pay for the services rendered and expenses incurred pursuant to this authorization. Further, I will not hold the Jewish Community Center or their Officers, Directors, Administrators, Teachers, Personnel, or Employees financially responsible for the emergency care and/or transportation for said child. The authority granted herein will expire one year from acknowledged date.

I give permission for my child to participate in all activities of the Jewish Community Center of Salt Lake City, including swimming and field trips. I understand that on field trips my child may be transported by bus or private automobile.

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp/afterschool activites, except as noted.

Parent/Guardian Signature_____ **Date**_____

Return form to: I.J. & Jeanné Wagner JCC 2 N. Medical Dr. Salt Lake City, UT 84113 Fax: 801-581-0718 Attn: Youth & Teen Dept.