

Fair Lawn Jewish Day Camp
Personal Health and Medical Record 2010

PROCEDURE:

- 1) Please complete this medical record.
- 2) Read and sign the second side of this medical record.
- 3) Contact your physician and obtain a copy of your child's most recent immunization record.
- 4) Submit both the medical record and the immunizations to the FLJDC office.

Camper/Staff Member's Name _____		Gender (circle one) <u>M</u> / F	
Age _____	D.O.B. (mm/dd/yy) _____		
Street Address _____		City _____	State _____ Zip _____
Home Phone _____	Father Cell _____	Mother Cell _____	
Physician _____		Phone _____	
School _____		School Phone _____	

EMERGENCY CONTACTS

One Name _____ Relationship _____
 Phone _____ Alternate Phone _____

Two Name _____ Relationship _____
 Phone _____ Alternate Phone _____

PLEASE MARK ANY/ALL AREAS IN WHICH YOU/YOUR CHILD HAS A HISTORY:

Y	N	Year	Details	Y	N	Year	Details
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

PLEASE CIRCLE THE CORRECT RESPONSE:

Date of most recent medical exam _____	Y	N
Does the school your child attends require him/her to have a shadow?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been diagnosed with any behavioral, mental, or neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any current health problems?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child under medical care or taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any surgery, illness, or change in health status since last complete physical exam?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any allergies ?	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes" explain here:

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AUTHORIZATION

To the best of my knowledge, this history is correct and complete. All camp activities are permitted, except as specifically noted herein. In the event of an EMERGENCY, I hereby give permission to Fair Lawn Jewish Day Camp to hospitalize, select a physician secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. I hereby give permission for the Camp Administration to verify that information contained in this history is true.

(Signature of Parent/Guardian)

(Date)

(Signature of Applicant- if over 18)

(Date)

MEDICATION AUTHORIZATION

FLJDC does not administer any prescription drugs to children under any circumstances. If a child is on medication, it must be administered by the parent/guardian, preferably outside camp hours. FLJDC only provides over-the-counter drugs (i.e. Advil, Benadryl) only with written parental consent, from a personal supply provided and labeled by the parent before camp begins. If your child requires such medication, please sign and date the statement below.

I, _____, hereby give my permission for the health director at FLJDC to administer over-the-counter medication to my child/ren, _____, once I have been contacted and have determined that the situation warrants such measures. I have provided the camp with a labeled supply of said medication for my child.

(Signature)

(Date)

Please specify the medication: _____