



THIS FORM MUST BE RECEIVED BY MAY 18, 2012 FOR ALL SUMMER CAMPS!

Please return to: Jewish Community Association of Austin Attn: Youth and Teen 7300 Hart Lane Austin, TX 78731

2012 JCC Summer Camps/Kids Connection Admission/Health Statement Form

Please detach this form from the packet and give to your physician who must sign based on an examination done within the past 12 months.

Date of Last Examination (must be within 12 months of admission): \_\_\_/\_\_\_/\_\_\_

Student's Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Can the above named child participate in general children's activities? Including, but not limited to: Gymnasium, field, playground and pool activities/games? [ ] Yes [ ] No

Comments: \_\_\_\_\_

Signature of Licensed Medical Professional \_\_\_\_\_

Name (please print) \_\_\_\_\_ Title \_\_\_\_\_

Office Address \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

FOR PARENT/GUARDIAN USE ONLY:

I \_\_\_\_\_ affirm the above named physician at the above mentioned address has examined my child with in the past 12 months and my child is able to participate in the JCC Summer Camps and/or Kids Connection programs.

This is a requirement of the Texas Department of Family and Protective Services according to statute §746.611

Shot Record/TB Test Record Statement

I, \_\_\_\_\_, certify that my child's TB test and Shot records are current and on file at:

\_\_\_\_\_ School's Name School's Address

\_\_\_\_\_ School's Phone Number Child's Name Grade Entering Fall 2011

\_\_\_\_\_ Parent's/Guardian's Signature Date

**GENERAL INFORMATION (Please check any of the following that apply to your child)**

- Ear infections     Asthma     Diabetes     Headaches     Joint problems
- Bedwetting     Sleepwalking     Learning problems     Psychiatric care     Wears glasses/contacts
- Head injury     Chest pain     Back problems     Eating disorder     Convulsions/Seizures
- Chronic illness/condition     Wears a retainer     Has braces

Comments on the information above:

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**ALLERGIES (List all known)**

**Describe reaction and management of the reaction**

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Dietary/activity restrictions: \_\_\_\_\_

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Use this space to provide other information about your child's health:

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Is your child currently taking any medications? If so, please list them below:

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**\*\*We strongly recommend that campers who take medication during the school year take their medication during camp so that they can participate fully in camp activities\*\***  
**If your child will be taking medication during the camp day, you must fill out a MEDICATION AUTHORIZATION FORM. Forms are available in the Camp Office (735-8050).**

**INSURANCE INFORMATION**

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

If so, indicate carrier or plan name \_\_\_\_\_    Group # \_\_\_\_\_

Carrier address \_\_\_\_\_

Name of insured \_\_\_\_\_    Relationship to participant \_\_\_\_\_

SSN of policyholder or insurance ID number \_\_\_\_\_

**PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:**

I hereby give permission to the medical professional selected by the Camp Director to order X-rays and routine tests, to provide treatment, or to release any records necessary for insurance purposes. I also give permission to the Camp Director to provide or arrange 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. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian: \_\_\_\_\_    Date: \_\_\_\_\_

Print name: \_\_\_\_\_    Relationship to Camper: \_\_\_\_\_