PLEASE RETURN TO:

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

JCC SUMMER CAMPS & KIDS CONNECTION

2014-2015 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 FIRST NAME: _____ **LAST:** _____

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: _____

Address: _____ City: _____ Zip: _____

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: _____ Address: _____

School's Phone Number: _____ Grade Entering Fall 2013: _____

_____ _____

PARENT SIGNATURE **DATE**

CHILD'S NAME: _____

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

☐ Ear infections	☐ Asthma	☐ Diabetes	☐ Headaches	☐ Joint problems
☐ Bed-wetting	☐ 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:

_____

_____

Allergies *(List all known)*:

_____

_____

_____

_____

Describe reaction and management of the reaction:

_____

_____

_____

_____

Dietary/activity restrictions: _____

_____

_____

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

_____

_____

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

_____

_____

**** 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 (512) 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 policy holder 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: _____