MEDICAL FORM FOR JCC SUMMER CAMPS INTERACTIVE VERSION

For all camps except Noah's Ark and Camp Keshet. Medical form must be received prior to your child attending camp. Please fill out the form, print it, sign it and then send it in.

Camp Name: _____ Camp Dates: _____

PLEASE PRINT. To be completely filled out by parent:

Camper's Name: _____ Birth date: _____

Address: _____ Phone: _____

School/Day Care attending prior to this camp season: _____ Gender: ☐ Male ☐ Female

Parent #1 Name: _____ E-mail: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Beeper: _____

Parent #2 Name: _____ E-mail: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Beeper: _____

Physician's Name: _____ Physician Phone: _____

Dentist's Name: _____ Dentist Phone: _____

1st Emergency Contact: *(someone other than a parent who is aware that his/her name is being furnished)*

_____

Name Relationship Home Phone Work Phone

2nd Emergency Contact: *(someone other than a parent who is aware that his/her name is being furnished)*

_____

Name Relationship Home Phone Work Phone

1. Does child have a medical condition, chronic or recurring, which may require emergency action while he/she is at Camp?
   ☐ Seizure ☐ Asthma ☐ Heart problem ☐ Insect sting allergy ☐ Bleeding disorder
   ☐ Diabetes ☐ Allergies ☐ Chronic illness ☐ Other _____
   Please explain: _____
2. Emotional or behavioral conditions or concerns: _____
3. Recent operations or serious injuries (dates): _____
4. Dietary needs: _____
5. Should there be any restriction of physical activity while at camp? _____
   If yes, specify nature and duration of restriction: _____
6. Is child on any daily medications? ☐ Yes ☐ No Has child been on any medications this past year? ☐ Yes ☐ No
   Please list: _____
   Will child be taking any medication while at camp? ☐ Yes ☐ No If yes, please attach a written doctor's order.

This must be completed for your child to attend camp! (Required by Maryland State Health Dept.)

7. Date of last tetanus inoculation: _____

8. Do you carry family medical/hospital insurance? ☐ Yes ☐ No
   If so, indicate carrier: _____ Policy or group # _____
9. Please indicate the names of those individuals who are authorized to pick up camper (picture ID will be required)
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____
10. Discretionary Medications Administration Consent
    ☐ Yes, I give permission for my child to receive the following medications as deemed necessary by the Registered Nurse: Acetaminophen, Ibuprofen, chewable antacid, Diphenhydramine (Benadryl, etc.), anti-itch lotion, anti-bacterial ointment, throat lozenges. I understand that generic equivalent medications may be used in place of more expensive brand-name items. These medication will be administered by the Registered Nurse or other qualified personnel in accordance with established protocols developed by the Baltimore County Department of Health.
    ☐ No, I do not want any of the above medications given to my child at camp.

Parent Signature: _____ Date: _____