Dear Parents,

The following forms must be submitted to the preschool office before your child will be admitted to The Weinstein School/Camp Marie Benator 2012-13 School and Camp Program:

- ☐ Master Profile
- ☐ Health Form (signed and dated by your doctor's office)
- ☐ Sunscreen & Topical Ointment Form
- ☐ 3231 Immunization Form (obtained from your doctor's office)
- ☐ Food Allergy Action Plan (*if applicable)*

All required forms are included in this packet, with the exception of the 3231 Immunization Form that must be obtained from your child's doctor's office.

No child will be permitted to attend without all of the above forms on file in our office.

Completed forms may be submitted:

- In person to the preschool office
- Scan & Email to preschool.forms@atlantajcc.org
- Fax to 770-396-2472
- Mail to: The Weinstein School
Marcus Jewish Community Center of Atlanta
5342 Tilly Mill Road
Dunwoody, Georgia 30080

If you have any questions, please contact:

- Janice Verner – janice.verner@atlantajcc.org, 678-812-3800
- Shannon Gardner – shannon.gardner@atlantajcc.org, 678-812-3800

2012 - 2013 MJCCA Preschool & Camp CHILD MASTER PROFILE

marcus jcc atlanta

THE WEINSTEIN SCHOOL   CAMP MARIE BENATOR   CAMP ISIDORE ALTERMAN JR.

Please complete one per child. Registration forms are also available online at www.atlantajcc.org

MJCCA Membership #	HD FD	Gender F M	Synagogue Affiliation
Child's Last Name	First	Middle	Nickname
Birthdate (mm/dd/yyyy)	Age (as of Sept. 1, 2012)	Child lives with Parents Mother Father Grandparents Guardian	
Marital status Married Single Divorced Widowed	For Divorced Parents or Legal Guardians:	Who is responsible for payment? Name Who has custody of this child? Name	
Parent/Guardian 1 Name	Mr. Mrs. Miss Ms. Dr.	Parent/Guardian 2 Name	Mr. Mrs. Miss Ms. Dr.
Home Address		Home Address	
City	State / Zip	City	State / Zip
Subdivision	County	Subdivision	County
Home Phone #	Fax #	Home Phone #	Fax #
Work Phone #	Cell #	Work Phone #	Cell #
Email address (please print)		Email address (please print)	
Occupation / Business Name	Business Address	Occupation / Business Name	Business Address
Grandparents' Names May be released to Grandparents Y N	Address Phone	Grandparents' Names May be released to Grandparents Y N	Address Phone

EMERGENCY CONTACT. Individuals other than Parents whom we may contact and release child to if parent cannot be reached.

Name	Relationship	Home Phone ____ Work Phone ____ Cell Phone ____	Address
Name	Relationship	Home Phone ____ Work Phone ____ Cell Phone ____	Address

Allergies: Does your child have any allergies? Yes No If yes, allergy form must be completed and picture of child attached.
If yes, please list allergies:

Additional Support: Does your child or has your child ever received any medical or educational therapies (PT, OT, Speech, etc.) Yes No
If yes, please list therapies: Date of last therapy session:

I understand and give my permission to MJCCA that my child and/or his voice may appear in printed material, photographs or visual and/or audio recordings from the MJCCA.	Yes No
I give permission for my address, phone numbers and email to be released to other preschool families.	Yes No
I hereby authorize MJCCA to include my child in supervised water activities (if applicable).	Yes No
I have read and fully understand the 2012-2013 MJCCA Preschool Policies that are available at www.atlantajcc.org.	Yes No

Authorization For Treatment: Should the need for medical attention arise; (and in case of our unavailability), as parents or legal guardians, we want the MJCCA and/or staff to arrange and authorize medical treatment as necessary for our child,
Child's Medical Insurance Co.____________ Group # ____________ ID # ________

The MJCCA will use the nearest available hospital. Should specialist advice or treatment be required, our preferences are:

Doctor ____________ Address____________ Ph________

Dentist____________ Address____________ Ph________

In the absence of a parent or guardian, I hereby give authorization I do not give authorization
to the named emergency contact person to have access to my child's health information.

This information is complete to the best of my knowledge.

Parent/Legal Guardian Signature

____

Date ____________

The Weinstein School at Zaban Park	678-812-3800	5342 Tilly Mill Road, Dunwoody, GA 30338	770-396-2472(f)

2012 - 2013 MJCCA Preschool & Camp HEALTH FORM

marcus jcc atlanta

THE WEINSTEIN SCHOOL CAMP MARIE BENATOR CAMP ISIDORE ALTERMAN JR.

Please complete one per child. Registration forms are also available online at www.atlantajcc.org

Child's Full Name	Date of Birth
Address	Phone Number

MEDICAL / IMMUNIZATION INFORMATION

Please, note that Georgia Health Form #3231 is required for all children. Families new to Georgia may provide an official document equivalent to the GA 3231 immunization record. All records must be in English.

Height	Weight	Gender F M

Chronic Medical Conditions Y N
If Yes, provide details.

Dietary needs or restrictions Y N
If Yes, provide details.

Medicine or Food Allergies Y N
If so, a completed Allergy Form is required along with this form.

Any regular or PRN medicines Y N
If so, which ones?

Does Child have any history of:

Vision Impairment or eye infection Y N If yes, what? ______________________

Hearing Impairment or ear infection Y N If yes, what? ______________________

Tubes in ears? Y N

Speech problems Y N If yes, what? ______________________

Rashes Y N If yes, what? ______________________

Are any restrictions on normal physical activities indicated? Y N
If Yes, provide details:

Physician's Name (please print)

Physician's Signature	Date
Physician's Address	Phone

In the event of an emergency, I hereby give permission to the physician selected by the director or other MJCCA official to order x-rays, routine tests, and treatment for the health of my child. In the event that I cannot be reached in an emergency situation, I hereby give permission for a physician selected by the preschool director or other MJCCA official to hospitalize, secure proper treatment for, and order injections and/or anesthesia and/or surgery for my child.

I authorize any physician, nurse or other health care provider to communicate with the staff and director of MJCCA Preschools, or his/her designee, about my child's medical condition, treatment and/or prognosis. I further authorize the director to discuss any medical conditions with his/her designee, or the child's teacher when the director, in his / her sole discretion, believes such communication to be in the best interest of the child.

I, the parent/legal guardian, assume all risks and hazards incidental to the conduct of activities and transportation to/from the activities. I understand that aspects of the MJCCA preschools & Camps may be physically and emotionally demanding. Both my child(ren) and I agree to follow any and all rules, guidelines, and safety instructions that may be provided by MJCCA staff. I recognize the inherent risk of injury or disability in activities. I understand that each participant must assume the risk of injury or disability that could result from any of these activities. I hereby release, indemnify, defend, save, and hold the MJCCA its officers, directors, trustees, employees, members, agents, and activity providers harmless, with respect to any and all claims or liability for any injury to my child(ren) from participation in any and all Camp activities and all claims by or on behalf of myself, my child(ren), or third parties for loss or damage unless the alleged loss is solely the result of the MJCCA's gross negligence or misconduct.

I give permission for this information on ______________________ to be shared with my child's school.
(Child's name)

SIGN HERE Parent/Legal Guardian Signature Date

Parent Name (please print)

The Weinstein School at Zaban Park	678-812-3800	5342 Tilly Mill Road, Dunwoody, GA 30338	770-396-2472(f)

Authorization to Dispense
Sunscreen / Bug Spray / Topical Ointment

590-1-1-.20(1) – Georgia Bright From The Start

Parental Authorization

Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give the Weinstein School/Camp Marie Benator/Camp Isidore Alterman Jr. of the MJCCA permission to apply one or more of the following topical ointments/preparations to my child, ______________________________________ in accordance with the directions on the label of the container.

______ Baby Wipes
______ Band-aids
______ Neosporin or similar ointment
______ Bactine or similar first aid spray
______ Sunscreen
______ Insect Repellent
______ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
______ Baby Powder
Other (please specify)
____
__________________ ____

Parent/Guardian Signature
____

Date ___________ / ___________ / ___________

School will maintain form in child's general file

3231 IMMUNIZATION FORM

This form must be obtained from your child's doctor's office.

Form **3231** (Rev. 10/01/2005)

Georgia Department of Human Resources
CERTIFICATE OF IMMUNIZATION

Form **3231** (Replaces Forms 3032 and 3227)

Lastname, Firstname I.
Child's Name (Last name first)

Birthdate

Parent/Guardian Name (Last name first)

Date of Expiration
(Next immunization or review of medical exemption due.)

OR

(Fill in X)
Complete For School Attendance
Child must be >= 4 years and have met all requirements for school attendance. The vaccine history section must be filled in.

***Georgia law requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply.**
Dates of Immunization ARE required for age 4 years and up. Dates are NOT required before the 4th birthday. See 3231INS and 3231REQ guides relative to Hib

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE	*Total Doses	Diagnosed	Serology +	History	Med. Exemption
	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY					
DTP, DTaP, DT, Td or Tdap											
Hepatitis B											
(Under Age 5) Hib											
OPV											
IPV											
MMR											
Measles											
Mumps											
Rubella											
Varicella											

SAMPLE FORM

***Notes:**
A licensed physician or Health Dept. official is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in in the appropriate box(es).
The certificate is NOT valid without names of the child and a parent/guardian, date of expiration OR "X" in complete for school box, legible name and address of the physician or health department, certified by signature and a date of issue
A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration.
When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility
Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the DHR.

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Dept.

Sample Q. Physician, M.D. P.C.
1234 Some Street
Fictitious Town GA 99999-9999

(555) 123-4567

Certified by (Signature)

Date of Issue

Food Allergy Action Plan

Name: ______________________________ **D.O.B.:** ___/___/____

Allergy to: ______________________________

Weight: ______ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

Extremely reactive to the following foods: ______________________________

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): ______________________________

Antihistamine (brand and dose): ______________________________

Other (e.g., inhaler-bronchodilator if asthmatic): ______________________________

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

______________________ ________ ______________________ ________

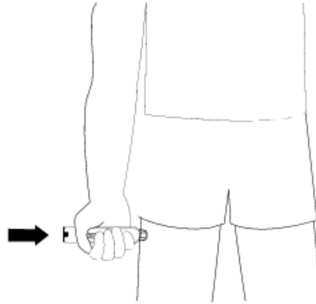
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER

EpiPen Auto-Injector and EpiPen Jr Auto-Injector Directions

- First, remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)_____-_________) Doctor:________________ Phone: (___)_____-_________
Parent/Guardian:____ Phone: (___)_____-_________

Other Emergency Contacts

Name/Relationship: ____ Phone: (___)_____-_________
Name/Relationship: ____ Phone: (___)_____-_________