

2017 MEDICAL FORM FOR JCC DAY CAMP

Return no later than June 5, 2017 to: JCC, 60 South River Street, Wilkes-Barre, PA 18702-2493

Little Menschen (Ages 2-3) K/Ton Ton (Ages 4-6) Nagila (Grades 2-4) Campers (July 10-Aug 4) Mitzvah (Grades 5-7) CIT (Grades 8-9 June 26-Aug 4)

Please select the weeks attending:

WK 1 (June 19 - 23) WK 2 (June 26 - 30) WK 3 (July 3-7 No Camp July 4) WK 4 (July 10 - 14) WK 5 (July 17 - 21) WK 6 (July 24 - 28) WK 6 (July 24 - 28)
 WK 7 (July 31 - August 4) WK 8 (August 7 - 11) WK 9 (August 14 - 18) FULL TIME CAMPER Overnight Camp (July -16 July 21) Overnight Camp (July -30 - Aug 4)

Camper's Name:

_____ Sex: M F

Home Address _____ *Last* _____ *First* _____ *Middle*

Parent/Guardian II: _____ Date of Birth _____ / _____ / _____
 Home Phone: _____ Cell Phone: _____ Business Phone: _____

Address: _____ Email _____

Parent/Guardian II: _____ Home Phone: _____ Cell Phone: _____ Business Phone: _____

Address: _____ Email _____

IN AN EMERGENCY, CAMP STAFF SHOULD NOTIFY, IN ORDER OF PREFERENCE (include parents' name if applicable):

1. Name: _____ Relationship: _____ Day Phone: _____ Cell Phone: _____

2. Name: _____ Relationship: _____ Day Phone: _____ Cell Phone: _____

Congenital defects	Yes	No		Yes	No		Yes	No
Allergies								
Seasonal	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>	Hemilia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Drug	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Illness			Infectious			Operations		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Immunization record. Enter month/day/year.

Diphtheria-Tetanus-Pertussis DTP 1 / / 2 / / 3 / / 4 / / 5 / /

Or Diphtheria-Tetanus (DT) 1 / / 2 / / 3 / / 4 / / 5 / /

Measles (Rubeola or Red*) 1 / / 2 / / **or Measles Serology: Date** _____ **Blood Titer** _____

*Must be administered at age 12 mos. or older

German Measles (Rubella*) 1 / / 2 / / **or Rubella Serology: Date** _____ **Blood Titer** _____

*Must be administered at age 12 mos. or older

Mumps 1 / / 2 / / **or Mumps disease diagnosed by a physician at** _____ / _____ / _____

*Must be administered at age 12 mos. or older

Hepatitis B Vaccine 1 / / 2 / / 3 / / **Chicken Pox Vaccine Yes** _____ **No** _____

*Not Required By Law

If child is presently taking medication, please list below. NOTE: All medicine must be labeled with a written instruction sheet and signed by guardian.

Physician's Signature: _____

Phone: _____ Name of Insurance Company: _____

Signature of Parent/Guardian: _____ Cell Phone: _____

E-Mail Address: _____

Name & Phone Number of Pediatrician: _____