EDLAVITCH DCJCC

Health History & Profile Form

The information on this form is gathered to assist us in identifying appropriate care and to determine fitness to engage in strenuous activities. **Please submit one form per child.**

_____ Birthdate: _____ Age: ____ Sex: _____
Last First Middle

Name of Parent(s) or Guardian(s): _____

Home Address: _____ Phone: ( ) _____
Street City State ZIP

Allergies (medication, food and other). Please describe reaction(s) and management of the reaction.

_____

_____

Medications Being Taken

Important Note: The Edlavitch DCJCC discourages administration of medication to students during After School Programming. Any necessary medications which can possibly be administered before or after After School Programming should be so prescribed. If ABSOLUTELY necessary, however, After School personnel will administer medication to students during After School Programming according to procedures outlined on this page.

If the student will take medications during After School, please make arrangements to have a parent or other adult bring a month's or session's supply of the medication to our After School Staff. We cannot accept medication directly form the children themselves. The medication packaging should identify the medication, the prescmake ribing physician (if a prescription drug), the dosage and the frequency of administration.

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely, whether or not during After School hours.

☐ This person takes NO medications on a routine basis.

☐ This person needs to take the following medications DURING After School hours:

Med #1 _____ *Dosage* _____ *Specific times taken each day:* _____

Reason for taking: _____

Med #2 _____ *Dosage* _____ *Specific times taken each day:* _____

Reason for taking: _____

Attach additional pages for more medications.

☐ This person takes the following medications NOT during After School hours:

Med #1 _____ *Dosage* _____ *Specific times taken each day:* _____

Reason for taking: _____

Med #2 _____ *Dosage* _____ *Specific times taken each day:* _____

Reason for taking: _____

Attach additional pages for more medications.

Restrictions and Considerations

List the dietary restrictions that apply to this camper. All snacks brought from home must be meat-free, shellfish-free, and peanut-free. _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary).

_____

General Questions:

Has/Does the Participant:	No	Yes		No	Yes
1.) Had any recent injury, illness or infectious disease?			16.) Ever had back problems?		
2.) Have a chronic or recurring condition?			17.) Ever passed out during or after exercise?		
3.) Ever been hospitalized?			18.) Ever had problems with joints (e.g. knees, ankles)?		
4.) Ever had surgery?			19.) Have any skin problems (e.g. itching, rash, acne)?		
5.) Have frequent headaches?			20.) Have diabetes?		
6.) Ever had a head injury?			21.) Have asthma?		
7.) Ever been knocked unconscious?			22.) Had mononucleosis in the past 12 months?		
8.) Wear glasses, contacts or protective eyewear?			23.) Had problems with diarrhea/constipation?		
9.) Ever had frequent ear infections?			24.) Ever had an eating disorder?		
10.) Have an orthodontic appliance being brought to camp?			25.) Ever had emotional difficulties for which professional help was sought?		
11.) Ever been dizzy during or after exercise?			26.) *If female*: Begun menstruating?		
12.) Ever had seizures?			27.) *If female*: Have a normal menstrual history/cycle?		
13.) Ever had chest pain during or after exercise?			27.) *If she has not menstruated,* have you spoken to her about it?		
14.) Ever had high blood pressure?			28.) Any special considerations?		
15.) Ever been diagnosed with a heart murmur?					

Explain any "Yes" answers, noting the number of the question(s). _____

Insurance: Insurance carrier or plan name: _____ Policy/Group # _____

Please include a picture of the front and back of your insurance card in this space:

Parent/Guardian Authorizations: *This health history form is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.*

I hereby give permission to the EDCJCC to provide routine health care and seek emergency medical treatment including ordering X-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the EDCJCC to arrange necessary related transportation for me/my child.

Signature_____ Printed Name: _____ Date: _____