CENTER FOR YOUTH & FAMILY
Jewish Community Center of San Francisco
3200 California Street, San Francisco, CA 94118
www.jccsf.org

Rabin Summer Programs
Health History Form

Please fill this form out completely. We cannot use forms from previous years.
Children without completed Health History Forms will not be permitted to attend any camp programs.
Our staff may need this information in the event your child needs medical attention.

Child's Name ____ Birth date____________ Sex____ Age_____

Parent or guardian 1____

Home Address ____

Home Phone (______) _______-__________ Work Phone: (______) _______-__________

Parent or Guardian 2____

Home Address ____

Home Phone (______) _______-__________ Work Phone: (______) _______-__________

If parent/guardian is not available in an emergency, notify:

Name ____________________________________Relationship: ___________________________

Home Phone (______) _______-__________ Work Phone: (______) _______-__________

Does your child…

➔Have allergies to foods, medicine or anything else? ____

____

➔Have a special diet to follow while in our program? (Kosher, vegetarian, etc...) _____________________________

____

➔Need to take medication while in our program? If so, please list the medications.
At the start of camp, we will request written instructions from you before administering medication to your child.

____

____

Does your child have any special needs? ρ Yes ρ No

If yes, what are those needs? Please explain in detail: ____

____

____

Please check the appropriate spaces that apply to your child. If you check "yes," please provide a brief explanation.

ρ Special activities restrictions ____

ρ Serious injuries or operations (in the past 3 years)____

ρ Hospitalized (How many times) ____

ρ Diabetes ____

ρ Jaundice ____

ρ Bleeding/Clotting Disorders ____

ρ Lung Disease ____

ρ Heart Trouble ____

ρ Convulsions ____

ρ Asthma ____

ρ Other medical concerns____ **-OVER-**

Must wear glasses	ρ Yes	ρ No	Has fainted recently	ρ Yes	ρ No
Must wear contact lenses	ρ Yes	ρ No	Bed wets	ρ Yes	ρ No
Has frequent nose bleeds	ρ Yes	ρ No	Sleep walks	ρ Yes	ρ No
Has a prosthesis	ρ Yes	ρ No	Has a hearing loss	ρ Yes	ρ No

Has your child had any of the following:

ρ Chicken Pox ρ Measles ρ German Measles ρ Mumps ρ Hepatitis A ρ Hepatitis B ρ Hepatitis C

Female only:

Has your daughter menstruated? ______ If not, has she been told about menstruation? ___________

Please provide us with specific medical information listed below:

Name of child's physician ____ Phone ____________________

Address ____ City/Zip __________________________

Health Insurance Information

Medical Insurance Company ____

Policy Number ____

Group Number:____

Immunization History

Please record the date (month & year) of basic immunizations and most recent booster doses.

VACCINE	**MO/YR**	**MO/YR**	**MO/YR**	**MO/YR**	**MO/YR**	**MO/YR**
DTP						
TD						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilius influenza B						
Hepatitis B						
Varicella (chicken pox)						

TB Mantoux Test

Date of last test: ____________ Result: ρ Positive ρ Negative

IMPORTANT-THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. AUTHORIZATION FOR TREATMENT: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or 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. The completed forms may be photocopied for trips out of camp.

I ρ authorize ρ do not authorize staff at the JCCSF day camp to administer the following Over the Counter (OTC) medication to the above named minor at the label-indicated dosage. Camp has a supply of the following medications: Topical Antiobiotic, Vionex skin wipes, and Calamine lotion. To my knowledge, all allergies for the named participant are listed on the form above. I understand that any OTC medication administered will be recorded and communicated to me.

Signature of parent or guardian ____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.