EMERGENCY TREATMENT FORM 2017

Authorization: I hereby give permission to the medical personnel selected by Camp JCC to secure and administer treatment, including x-rays, routine tests and hospitalization for the child named below:

Parent Signature:_____________________ Child's Name: ________________________ Date:_____________________

Home Phone:_________________________ Address: ____

Parent 1 Name: _____________________________________ Parent 2 Name: ______________________________

Parent 1 Work #:____________________________________ Parent 2 Work #: ______________________________

Emergency Name: __________________________________ Relationship:_________________ Phone:____________

Emergency Name: __________________________________ Relationship: ________________ Phone:____________

Doctor's Name: _____________________________________ Phone: ____

Doctor's Address: ____

Dentist's Name: ____________________________________ Phone: ____

Hospital: ____ Phone: ____

HEALTH HISTORY

(Check-giving approximate dates)
Frequent Ear Infections ____
Heart Defect ____
Convulsions ____
Diabetes ____
Bleeding/Clotting ____
Disorders ____
Hypertension ____
Psychiatric Treatment ____
Mononucleosis ____

Allergies
Hay Fever ____
Ivy Poisoning etc. ____
Insect Stings ____
Penicillin ____
Other Drugs ____
Asthma ____
Dairy Products ____
Peanuts ____
Tree Nuts ____
Other ____

Diseases
Chicken Pox ____
Measles ____
German measles ____

Is child currently receiving special help with emotional and/or behavioral issues at home or school (i.e. psychiatrist, social worker, counselor, etc.) Yes No

If yes, Name _________________________ Phone: ____

Do you carry family medical/hospital insurance Yes No

If yes, indicate:
Carrier: ____ Policy or Group # _________________________________