



## EMERGENCY TREATMENT FORM 2018

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 your 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 # \_\_\_\_\_