2019 PHYSICIAN'S STATEMENT & CONSENT TO TREAT

REQUIRED FORM

To ensure an informed response in case of an emergency, your child WILL NOT BE PERMITTED to attend J Day Camp without a completed 2019 Physician's Statement signed by a physician. Your child must have had an exam since September 1, 2017 and have a copy on file. RETURN THIS FORM BY MAY 1, 2019 (If signing up after this date, form is due immediately). Please return to Jewish Community Center, Attn: Day Camp Registrar, 2 Millstone Campus Dr, St. Louis, MO 63146 or Fax to Attn: Day Camp Registrar 314-442-3110.

THIS FORM TO BE COMPLETED BY A PHYSICIAN. FILL IN CHILD'S NAME AND FORWARD TO YOUR PHYSICIAN

Child's Name _____ Birth Date _____

Weight _____lbs Height_____ Is the current examination normal? Yes No

Note any abnormal findings

List name of drug (s) currently used, dosage, frequency needed

List any known allergies (drug, food, plants, insects, etc) _____

IMMUNIZATION DATES (Please complete this section or attach a copy of the current immunization record.)

DPT	_____	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	_____	_____
MMR/MR	_____	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____	_____
TB	_____	Reaction_____				
HEP-B	_____	_____	_____	_____	_____	_____

Is child under a physician's care for any conditions? If so explain _____

_____

Is any treatment/medication needed during program participation? _____

_____

Please describe any camp activities from which the child should be exempt for health reasons _____

_____

Is child under any dietary restrictions? If so, please explain _____

Please mark information pertinent to this child:

_____Anxieties	_____Heart Defect/Disease	_____Developmental Disability
_____Hearing Deficiency	_____Asthma	_____Attention Deficit Disorder
_____Behavioral Disorder	_____Down's Syndrome	_____Speech Delay
_____Glasses/Contacts	_____Hearing Aids	_____Tourette's syndrome
_____Seizure Disorder	_____Orthopedic Disability	_____Wheelchair
_____Autism	_____Blind	_____Walker
_____Social/Emotional Disorder		

Any other special concerns (including behavioral) _____

DATE OF EXAM_____**PHYSICIAN'S SIGNATURE**_____

Type or print Physician's name_____**Date Signed**_____

CONSENT TO MEDICAL TREATMENT

The Jewish Community Center and Day Camps have my permission to have a physician treat my child(ren) if needed during their participation in Day Camps or while on the property of the J. I authorize the Camp Director to use his or her judgment in arranging for medical care for my camper which the Camp Director deems necessary. I hereby consent to any first aid, medication, medical treatment or surgery deemed necessary by the Camp Director in his or her judgment. I release The J and its agents, employees, representatives, volunteers and assigns of and from all claims for injuries or damages incurred by my child in connection with the delivery of such care in good faith. This release is also a condition of participation in Day Camps. I consent that my child(ren) may be assessed and/or treated by the Camp Nurse or, if the Nurse is not available, by a designated Camp Staff in case of illness or injury. I agree to pay all expenses of care administered to my child(ren).

_____ _____

Parent/Guardian Signature Date