



THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN

NAME OF PROGRAM:

Confidential Medical Form

Name _____ Date of Birth ____ / ____ / ____ Age ____ SS# _____

Parent/Guardian: _____ Address _____ City _____ State _____ Zip _____

Telephone # _____ Cell Phone # (____) _____ Summer Address & Phone # _____

Business Telephone # (____) _____ Emergency Contact Person & Phone # _____ Relation _____

Check if child has or has had the following conditions

- | | | |
|-------------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Serious Injury | <input type="checkbox"/> Recurring Illness |
| <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Disability | <input type="checkbox"/> Bee Sting Allergy |
| <input type="checkbox"/> Allergic to Medication | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox |

Other Conditions: _____

Please indicate history of above and medication and/or treatment to be continued at camp _____

Would you like us to be aware of anything specific to assist us in the care of your child: (i.e. frequent colds, ear infections, stomach problems, insect bites, homesickness, and anxiety.)?

Please check if you have anything confidential that you would like to discuss with the nurse prior to your child's arrival at camp.

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

Authorization of consent to Treatment of minor temporarily separated from his/her parents

I the undersigned, parent(s) of _____, a minor, do hereby authorize NCSY Summer Programs as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician and surgeon at a Hospital or Doctor's office. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital / Private Doctors which the physician exercises his/her best judgement may deem advisable. The authorization shall remain effective, unless revoked in writing and delivered to said agents(s).

Parent/Guardian Signature _____ Date _____

Before you submit this form, please make sure you:

- Include your child's name and program at the top
- Have a parent/guardian sign the authorization box at the bottom left of this page
- Include a front & back copy of your health insurance card
- Save a copy of the completed form for your records

Please return **as soon as possible,**
but no later than **May 1st** to

TJJ, TJJ Ambassadors - Fax: 212-613-0790

GIVE, Michlelet, Kolllel - Fax: 212-613-0789

ICE, JOLT, Camp Sports, BILT - Fax: 212-613-0739

or

NCSY Summer Programs

11 Broadway, 14th floor

New York, NY 10004



**THIS SIDE TO BE COMPLETED
BY EXAMINING PHYSICIAN**

NAME _____

PROGRAM _____

Please indicate which medications are
acceptable for administration to this applicant:

Vaccines	Dates of Basic Immunization	Booster
DPT-DT-Tetanus		
MMR		
Polio		
Hepatitis A		
Hepatitis B		
HIB		
Varicella		

Name of Medication	Accepted	Not Accepted	Dosage	Alternative Medication
Acetaminophen (Tylenol)				
Antibiotic Ointment				
Anti-Diarrheal				
Anti-Fungal Cream				
Benadryl				
Claritin				
Cortisone Ointment				
Cough Syrup-DM				
Dramamine				
Gas-X				
Ibuprofen (Advil)				
Milk of Magnesia				
Pepto-Bismol				
Senna-Lax				
Sudafed				
Tums				
Tylenol Cold				
Tylenol Sinus				
Vasocon-A				
Visine				
Other:				
Other:				
Other:				
Other:				

I have examined the above named applicant on: _____

Note that the examination must have been within the last year.

- Patient's Blood Pressure: _____ Patient's Heart Rate: _____
- Patient's Height: _____ Patient's Weight: _____
- Patient had the following allergies: _____
- Medication and/or treatment to be continued at camp: _____

- In my professional opinion his/her condition does ___ / does not ___ preclude participation in an active camp program.
- Patient was found to be in good health with the following exceptions:

Physician's Signature: _____ Date: _____

No stamps will be accepted.

Physician's Name: _____

Telephone #: _____