



## MetroWest Jewish Day School April Vacation Camp HEALTH HISTORY UPDATE (to be filled out by parent)

Please complete this form and return it to the MWJDS office as soon as possible. The information it provides will offer considerable assistance to the camp in dealing with acute/emergency and chronic health problems should they arise during school hours.

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_

Child's Social Security Number \_\_\_\_\_

Name of child's physician(s) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

\_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name of child's dentist \_\_\_\_\_ phone ( ) \_\_\_\_\_

Name of child's orthodontist \_\_\_\_\_ phone ( ) \_\_\_\_\_

Health Insurance plan \_\_\_\_\_ Subscriber \_\_\_\_\_ ID # \_\_\_\_\_

*Please be sure to fill out every line in this section **completely***

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### **Health History** (check, giving approximate dates and details, including preferred treatments and medications):

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\_\_\_\_\_ Chickenpox \_\_\_\_\_

\_\_\_\_\_ seizures \_\_\_\_\_

\_\_\_\_\_ bleeding/clotting disorders \_\_\_\_\_

\_\_\_\_\_ skin problems \_\_\_\_\_

\_\_\_\_\_ dental/orthodontic problems \_\_\_\_\_

\_\_\_\_\_ frequent strep throats/tonsillitis \_\_\_\_\_

\_\_\_\_\_ Diabetes \_\_\_\_\_

\_\_\_\_\_ urinary tract problems \_\_\_\_\_

\_\_\_\_\_ frequent ear infections \_\_\_\_\_

\_\_\_\_\_ vision/wears glasses \_\_\_\_\_

\_\_\_\_\_ heart defect/disease \_\_\_\_\_

\_\_\_\_\_ hearing \_\_\_\_\_

\_\_\_\_\_ gastrointestinal disorders \_\_\_\_\_

\_\_\_\_\_ sleeping difficulties \_\_\_\_\_

\_\_\_\_\_ operations/serious injuries \_\_\_\_\_

\_\_\_\_\_ other (note: allergies/asthma are listed below)

\_\_\_\_\_ orthopedic problems \_\_\_\_\_

\_\_\_\_\_

**(Please complete both sides)**

MWJDS Camp Health History 2/11/2009

Has any member of the family developed any serious health problems within the past year? \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
Please indicate if your child has or has had any of the following and what treatment he or she receives or has received for it.

\_\_\_\_ hay fever \_\_\_\_\_

\_\_\_\_ severe poison ivy allergy \_\_\_\_\_

\_\_\_\_ **insect/bee sting allergy** \_\_\_\_\_ **Epipen?** \_\_\_\_\_

\_\_\_\_ medication allergies: list medications and reactions \_\_\_\_\_

\_\_\_\_ **food allergies:** list foods, reactions, treatment \_\_\_\_\_

\_\_\_\_ **Epipen?** \_\_\_\_\_

\_\_\_\_ asthma \_\_\_\_\_

\_\_\_\_ other allergic problems \_\_\_\_\_

Current medications: list ***ALL*** current medications taken:

<u>Name of medication</u>	<u>Reason for taking</u>	<u>Dose</u>	<u>How often?</u>	<u>What times?</u>
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Any specific activities to be encouraged or limited by physician's advice?

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_