



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***

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

_____ 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 _____