Rev. 7.16.16 Date _____

# ACHaD Department, Katz JCC Medical

## Participant Information

Participant's Name: _____Date of Birth_____ Age _____
Participant's Email: _____ Grade in Sept 2016 _____
Address: _____
City: _____ State: _____ Zip:_____

## Emergency Contacts

Parent/Guardian Name: _____(home)_____(work)_____(cell )_____
Parent 1 Email:_____
Parent/Guardian Name: _____(home)_____(work)_____(cell )_____
Parent 2 Email:_____
Additional Contact Name: _____(home)_____(work)_____ (cell)_____

## Restrictions

Is your child under any medical/physical restrictions? ❒ yes ❒ no

❒ Asthma ❒Hearing Loss ❒Diabetes ❒Visual Impairment ❒Seizures ❒Frequent headaches

❒Physical limitations ❒ Other _____

Check all that apply and explain restrictions in programs and activities that your child should avoid or participate in with limitations.

_____

_____

## Assistive Devices

Will your child be using use any Assistive Devices? ❒yes ❒no

Please explain:_____

_____

## Allergies

Is your child allergic to any medications/foods/insect stings or have any dietary restrictions? ❒ yes ❒no

*If yes, please be specific*

*Food allergies: (please check all that apply)*

❒Dairy ❒Nuts ❒Wheat Products ❒Fish ❒Eggs ❒Other (specify)

Describe reaction and management: _____

_____

*Medication allergies:* _____

Describe reaction and management _____

_____

*Environmental Allergies (please check all that apply)*

❒Insect Stings ❒Hay Fever ❒Animals ❒Other (specify) _____

Describe reaction and management:_____

_____

## Parent Permission

The information and health history provided on this form is accurate to the best of my knowledge. The JCC, its employees and program staff shall be held harmless of any omission or incorrect medical information provided. The person, herein named, has permission to engage in all activities except as noted. It is my intention that the program be treated as acting in loco parentis if the person named is a minor. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Parent's signature:_____ Date:_____