

# Kaleidoscope Creative Arts & Science Camp

Leventhal-Sidman Jewish Community Center  
333 Nahanton Street, Newton, MA 02459  
(617) 558-6523; (617) 244-5124

## Health Form

This side to be filled out by parent or guardian.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_  
Last First M.I.

Parent or Guardian 1 \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent or Guardian 2 \_\_\_\_\_ Home Phone \_\_\_\_\_

Home address \_\_\_\_\_  
Street and number City State Zip Code

Parent 1: work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Parent 2 work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Insurance company \_\_\_\_\_ Policy number \_\_\_\_\_

### Emergency Contact:

1. Name \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

2. Name \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

### HEALTH HISTORY (check and give approximate dates)

Ear infections (since age 5) _____	Chicken pox _____
Asthma _____	German Measles _____
Allergies _____	Measles _____
Allergy to Penicillin _____	Mumps _____
Hay Fever _____	Convulsions _____
Insect Stings _____	Diabetes _____
Poison Ivy, etc. _____	Rheumatic fever _____
Other _____	

Chronic or recurring illnesses \_\_\_\_\_

Food allergies \_\_\_\_\_

Please list current medications taken at home: \_\_\_\_\_

List medications to be taken at camp \_\_\_\_\_

IMPORTANT: Please notify office if this child is exposed to any communicable disease during the three weeks prior to participation.

### Parent's Authorization

To the best of my knowledge, this health history is correct. The person herein described has permission to engage in all prescribed physical activities, except as noted by me and the examining physician.

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp directors to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

→ Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL EXAMINATION**  
**To be filled out by LICENSED PHYSICIAN**

This examination must be performed within 12 months of individual's participation. Examination for some other purpose is acceptable. Examination is for determining fitness to engage in strenuous activities. Physicians may use their own office form in lieu of the questions below.

**IMMUNIZATION HISTORY (check and give approximate dates)**

DTP series booster \_\_\_\_\_  
Tetanus booster \_\_\_\_\_  
Polio \_\_\_\_\_  
OPV (Sabin) booster \_\_\_\_\_  
Typhoid \_\_\_\_\_  
Measles vaccine (live) \_\_\_\_\_  
Tuberculin test \_\_\_\_\_  
German measles (Rubella) \_\_\_\_\_  
Mumps vaccine (live) \_\_\_\_\_  
Smallpox \_\_\_\_\_  
Chicken pox \_\_\_\_\_  
Other \_\_\_\_\_

Code:

S – Satisfactory    X – not satisfactory (explain)    O – not examined

Hgt. _____	Wt. _____	B.P. _____	Hgb. Test _____	Urinalysis _____
Eyes _____	Extremities _____	Glasses _____	Posture _____	Ears _____
Skin _____	Nose _____	Allergy (please specify) _____	Throat _____	
Teeth _____	Heart _____	Lungs _____	Abdomen _____	Hernia _____

Please list all medication taken regularly during this past school year: \_\_\_\_\_

Recommendations and restrictions while in camp: \_\_\_\_\_

Special diet: \_\_\_\_\_

Medication requirements (name and instructions): \_\_\_\_\_

Swimming: \_\_\_\_\_

Strenuous activity: \_\_\_\_\_

Does this child receive any special needs services either privately or at home? \_\_\_\_\_

Other: \_\_\_\_\_

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically capable of engaging in physical activities, except as noted above.

Examining physician \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_