



Camp(s) your child will be attending: <input type="checkbox"/> Camp Shalom <input type="checkbox"/> Sports Camp Specify: _____

PERSONAL DATA FORM

Camper's Name _____

Home Phone _____ E-mail Address _____

Birth date ____/____/____ Age as of 06/01/08 ____ Sex ____ M ____ F Grade Entering Fall '08 _____

Is there any specific person(s) to whom your child should **NOT** be released? _____

Parent's Name _____

Parent's Home Phone _____ Work Phone _____ Cell/Pager _____

E-mail address _____

Parent's Name _____

Parent's Home Phone _____ Work Phone _____ Cell/Pager _____

E-mail address _____

EMERGENCY CONTACTS (2 Required)

Name _____ Relationship to Child _____

Home Phone _____ Work Phone _____ Cell/Pager _____

Name _____ Relationship to Child _____

Home Phone _____ Work Phone _____ Cell/Pager _____

Name _____ Relationship to Child _____

Home Phone _____ Work Phone _____ Cell/Pager _____

SPECIAL NEEDS

Please describe any specific needs (Allergies, Attention Deficit Disorder, seizures, fears, etc) your child may have so that we may help support him/her in the best way possible:

In case of medical emergency, I authorize the JCAA and its adult staff or representatives to consent to any medical treatment and/or hospital care, which is rendered to the minor, named above, under the supervision of any licensed physician. It is the responsibility of every individual, his or her parents or legal guardian to provide for his or her own medical coverage while participating in all JCAA activities. In addition, I grant permission for the above named minor to participate in all camp activities and for photos including the above named minor to be used for JCAA marketing purposes unless otherwise indicated in writing. My child has permission to go on all field trips and camp overnights and to swim under the supervision of certified lifeguards. My child also has my permission to be transported by the JCAA.

Signature of Parent or Guardian

Date

GENERAL INFORMATION (Please check any of the following that apply to your child)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Head injury | <input type="checkbox"/> Wears glasses/contacts | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Chronic illness/condition | <input type="checkbox"/> Joint problems |
| <input type="checkbox"/> Wears a retainer | <input type="checkbox"/> Has braces | | |

Comments on the information above:

ALLERGIES (List all known)

Describe reaction and management of the reaction

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Dietary/activity restrictions: _____

Use this space to provide other information about your child's health:

Is your child currently taking any medications? If so, please list them below:

****We strongly recommend that campers who take medication during the school year take their medication during camp so that they can participate fully in camp activities****
If your child will be taking medication during camp, you must fill out a MEDICATION AUTHORIZATION FORM. Forms are available in the Camp Office (735-8050).

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No
If so, indicate carrier or plan name _____ Group # _____
Carrier address _____
Name of insured _____ Relationship to participant _____
SSN of policyholder or insurance ID number _____

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:

I hereby give permission to the medical professional selected by the Camp Director to order X-rays and routine tests, to provide treatment, or to release any records necessary for insurance purposes. I also give permission to the Camp Director to provide or arrange related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian _____ Date _____
Print name _____ Relationship to Camper _____



Camp(s) your child will be attending:

Camp Shalom

Sports Camp

Specify: _____

**SWIMMING INFORMATION
(To be completed by parent or guardian)**

As you know, your child will be participating in swimming as one of the many activities in Camp. Camp Shalom Campers (except for Habonim, Neharim, and CITs), participate in swimming lessons. Sports Campers enjoy free swim as well as Campers participating in the Specialty Camps offered during Session IV (except for Chess, Magic, and Tiny Tumblers). Please review the attached Form "Swim Levels Description" to help you decide which level you believe your camper belongs to. Please feel free to include any additional comments we should be aware of to ensure your child's safety and enjoyment during swim time.

Camper's Name _____ Grade _____ Skill Level: _____

Additional Comments: _____

Is there any information you feel the Aquatics Director should be aware of? _____

PLEASE NOTE: We place children in swim groups according to their ability at the beginning of the camp session. If your child has not done a great deal of swimming since last summer, he/she may be placed at a level he/she has already passed. Please explain to your child that it may be necessary to review skills learned previously in order to move on to a new level. Campers enrolled on a weekly basis may not be able to participate in swim lessons.

PLEASE RETURN ALL FORMS TO:

JEWISH COMMUNITY ASSOCIATION OF AUSTIN
ATTN: CONNIE JIMENEZ
7300 HART LANE
AUSTIN, TX 78731

Fax (512) 735-8037

scan and e-mail to: connie.jimenez@shalomaustin.org

ALL FORMS MUST BE IN THE CAMP OFFICE BEFORE JUNE 2, 2008

CAMPERS MAY NOT ATTEND CAMP UNLESS ALL FORMS ARE COMPLETE



JCC Summer Camps 2008 Health Form

Mail this form to the address below no later than:
June 2, 2008

Jewish Community Association of Austin
Attn: Connie Jiménez
7300 Hart Lane – Austin, TX 78731
or Fax (512) 735-8037

This page is to be completed by a physician based on an examination done within the past year.

Camper's Name: _____ Age as of 06/01/08 _____

Address: _____

DOB: ____/____/____ Gender: __ Male __ Female Date of Last Examination _____

Height _____	Does this child have a convulsive disorder?	Yes	No
Weight _____	Can this child participate in strenuous activity?	Yes	No
Blood Pressure _____	Does this child have a history of back problems?	Yes	No
	Does this child have a history of ear problems?	Yes	No
	Does this child have diabetes?	Yes	No
	Does this child have allergies that may affect participation?	Yes	No

Comments on the information above:

This child is under the care of a physician for the following reason(s):

Current treatment (include current medication):

Treatment to be continued at camp:

Additional health information:

Immunization History: Give YEAR of last immunization or booster for:

_____ DPT Series	_____ Tetanus Booster	_____ Polio
_____ Mumps	_____ Measles (Rubella)	_____ Varicella (Chicken Pox)
_____ Tuberculin Test	_____ Hepatitis B Series	

Signature of Licensed Medical Professional _____

Name (please print) _____ Title _____

Office Address _____ Phone _____ Date _____