Summer Program 2017
Medical Information and Release
(Campers need to be 7 or turning 7 years of age this summer 2017 in order to participate.)

(www.jumpstartyouth.net)

Parent / Guardian

_____

Address

_____

_____

Day Phone Eve Phone

_____

Non-Custodial Parent if applicable

_____

Address

_____

Phone

_____

Health Care Carrier

_____

Policy Number Address

_____

Person to call in case of Emergency

_____

Child's Name (Last, First, MI)

_____

Nick Name

_____

Address (If Different)

_____

_____

Sex Weight DOB Age

_____

Name of School

_____

Grade

_____

Child's Pediatrician

_____

_____

Relationship Telephone Number

_____

Medical Information

Does your child have any dietary restriction? No _____

Yes (Explain)_____

_____

Does your child require any assistive devices? NO_____

Yes(Explain)_____

_____

Does Your child have any allergies? No_____ Yes_____

To Medications? _____

To Foods?_____

Has your child ever required medication for an allergy emergency

NO_____ YES_____ EPI-PEN_____

When_____ Benedryl_____

Medications (For Emergency Informational purposes) **No meds will be distributed at the Summer Program.**

Medication	Dose	Frequency per day	Time of Day	Only as necessary

(Please attach a copy of your insurance card to this form!)

Medical History:

Include any chronic conditions for which your child will be receiving medications or treatment during this program. Please use this space to note any additional information or suggestions regarding your child which may be helpful. All information is Strictly Confidential.

_____

_____

_____

_____

_____

_____

_____

IMMUNIZATION RECORDS

Please attach a photocopy of your child's immunization records to this form. The Massachusetts Dept. of Health requires a complete record of all immunizations received prior to attending Camp. We require dates of the following Immunizations: Tetanus, DPT, Polio, Measles, Mumps, Haemophilius Influenza type A and type B, Hepatitus B, Rubella and a vaccine or the date of the following Diseases: Chicken Pox and German Measles.

Emergency Treatment Information:

This health history is correct and my child has permission to engage in all activities except those which are noted. I hereby give permission to the physician selected to secure proper treatment for my child. In the event I or an emergency guardian cannot be reached I give permission to Health Care Staff to administer proper health care for my child which includes emergency treatment.

_____ _____

Signature of Parent / Guardian Date

Medical Form 2017 CHECKLIST

☐	**Page 1** Camper/Family Info and Emergency Contacts (To Be Filled Out By Parent / Guardian)
☐	**Page 2** Medical Conditions, Physician and Insurance Information (To Be Filled Out By Parent / Guardian)
☐	**Page 2** Signed Declaration (To Be Filled Out and Signed By Parent / Guardian)
☐	Copy of Insurance Card(Attached)
☐	Copy of Immunization Record(Attached)

Mail To: **JumpStart Youth Connection Inc.**
Attention: Summer Program 2017
182 Whitehall Road Amesbury, MA 01913