Arthur M. Glick Indianapolis JCC After School Care 2023-2024

Family Health Form: Grades K–5

Child 1's Full Name	Date of Birth	Gender	Grade (Current)
Child 2's Full Name	Date of Birth	Gender	Grade (Current)
Child 3's Full Name	Date of Birth	Gender	Grade (Current)

Family Address	Family Phone Number	Name of Family Physician	Phone # of Family Physician

Parent/Guardian #1 Name	Email	Cell Phone Number	Profession
Parent/Guardian #2 Name	Email	Cell Phone Number	Profession

Emergency Contact #1 Name	Relationship	Phone Number
Emergency Contact #2 Name	Relationship	Phone Number

_____ **My child(ren)'s immunizations are up-to-date and on file at my child(ren)'s school.**
Initial

Please explain any "yes" answers on the back of this form, or contact Myranda Tetzlaff at mtetzlaff@JCCindy.org.

	Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No
1. Any allergies (food, insects, medication, etc.)?	☐	☐	☐	☐	☐	☐
2. Any concerns about general health (eating and sleeping habits, asthma, weight, etc.)?	☐	☐	☐	☐	☐	☐
3. Any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?	☐	☐	☐	☐	☐	☐
4. Any prescription medication (daily or occasionally)? Insulin pump? **Prescription drugs must be in the original pharmacy bottle, including time medication is to be administered. A Medical Permission Form must be signed by the parent/guardian.**	☐	☐	☐	☐	☐	☐
5. Any other specific illnesses, social/emotional challenges, or behavior problems?	☐	☐	☐	☐	☐	☐
6. Any hospitalization, operation or major illness (specify problem)?	☐	☐	☐	☐	☐	☐
7. Any significant injury or accident (specify problems)?	☐	☐	☐	☐	☐	☐
8. Would you like to discuss anything about your child's physical, mental or behavioral health with JCC Youth staff?	☐	☐	☐	☐	☐	☐
9. My child receives early intervention services, Behavior Intervention Planning or social skills training (please circle). **If yes, must provide copy of plan and schedule meeting with program director prior to acceptance into the program.**	☐	☐	☐	☐	☐	☐

Patient Authorization: This health history provided herein is correct and complete in every sense. The child(ren) herein described has permission to engage in all program activities except as noted herein. I hereby give permission to the program to provide routine health care, administer prescribed medications and seek emergency medical treatment including x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the program to arrange necessary related transportation for the child(ren). In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the program to secure and administer treatment, including hospitilization, for the child(ren) named above.

Parent/Guardian Signature	Date

_____ Staff Initial

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Medical Permission Form

Child's Name: _____

Date of Birth: _____

Grade: _____

Please list any medication your child will need during program hours:

Medication	**Dosage**	**Time(s)**

_____

Signature of Parent/Guardian **Date**

Primary Phone: _____ Emergency Phone: _____

- If medications (including over-the-counter) must be given during program hours, please complete this Medical Permission form. Medications that are to be administered during program hours must be given directly to JCC Youth staff by a parent/guardian (please do not send with child). Medications should be in the original container, accompanied by written prescription and and clearly labeled with the child's name, directions, parent's name and phone number and physician's name and phone number.