STUDENT INFORMATION PACKET

PLEASE PRINT

PLEASE RETURN TO THE GESHER OFFICE PRIOR TO START DATE

Child's Name: _____ Date of Birth: _____

HEALTH HISTORY

Please complete the following health-related questions and **attach a copy of your child's "Health Assessment" or "School Form" (with immunization records) prepared by a physician**.

To grant permission to administer ANY medications (including over the counter) the enclosed "Child Health Form for Physician" must be completed, as well.

	Y	N
1) Had any recent injury, illness or infectious diseases?		
2) Have a chronic or recurring illness/condition?		
3) Ever been hospitalized?		
4) Ever had surgery?		
5) Have frequent headaches?		
6) Ever had any serious injuries?		
7) Wear glasses, contacts or protective eyewear?		
8) Ever had frequent ear infections?		
9) Ever been dizzy or passed out during or after exercise?		
10) Ever had seizures or other epileptic symptoms?		
11) Ever had heart trouble?		
12) Ever had back trouble?		
13) Ever had problems with joints (knees, ankles, etc.)?		

	Y	N
14) have any skin problems (itching, rash, acne, etc.)?		
15) Have diabetes?		
16) Have asthma/wheezing/shortness of breath?		
17) Had mononucleosis within the past 12 months?		
18) Had problems with diarrhea/constipation?		
19) Have problem with sleepwalking/falling asleep?		
20) Receive treatment for a speech delay?		
21) Have a history of bed-wetting?		
22) Have an eating disorder?		
23) Have a hearing deficiency?		
24) Ever had emotional difficulties for which Professional help was sought?		
25) Traveled outside the country in the past 9 months?		
26) If female, have problems with periods/menstruation?		
27) Has the child been exposed to any contagious diseases or illnesses in the 6 months before the start of the program?		

If you answered yes to any of the above, please describe: _____

_____

_____

CONFIDENTIAL PARTICIPANT INFORMATION

PLEASE PRINT

Child's Name: _____ Date of Birth: _____

Our goal is to insure a wonderful and safe experience for your child. All information provided will be held in the strictest of confidence and is used to inform and sensitize the staff to the specific needs of your child.

1. Has your child expressed any concerns about coming to our program?

2. Has there been a recent event in the family that may be of concern to your child (e.g. moving, divorce, death, etc.)?

3. Does your child have any special needs or health concerns for which s/he has received or is receiving medical treatment?

4. Does your child have any physical or dietary restrictions (vegetarian, vegan, kosher, etc.)?

5. Is your child presently (or recently) engaged in treatment or counseling with a social worker, psychologist or psychiatrist?

6. What are your child's hobbies? Does s/he participate in any extracurricular activities?

7. How does your child relate to his/her peers? Would you say your child is outgoing or shy?

8. How would you describe your child to someone who has never met him or her?

9. How do you work out problems or disagreements with your child and his siblings/peers?

10. Please list other JCC programs that your child attends.