HEALTH INFORMATION FORM

PLEASE SUBMIT COMPLETED FORMS TO FirstSummer@JKCP.COM
OR BY MAIL TO
FIRST SUMMER, 610 S. HENDERSON RD, KING OF PRUSSIA PA 19406

STUDENT NAME _____
LAST FIRST

BIRTH DATE / / **GENDER** ☐ Male ☐ Female **Last Four Digits of Social Security #** _____
(MM / DD/ YYYY)

Drug Allergy: _____

Drug Allergy Severity: ☐ Annoying ☐ Mild ☐ Moderate ☐ Severe ☐ Life threatening

Please provide any details about the student's drug allergy. This should include the name of the drug, notes about the severity and symptoms related to this allergy.

Food Allergies: ☐ Dairy ☐ Eggs ☐ Nut ☐ Peanut ☐ Seafood ☐ Shellfish ☐ Soy ☐ Wheat ☐ Other

Food Allergy Severity: ☐ Annoying ☐ Mild ☐ Moderate ☐ Severe ☐ Life threatening

Please provide any details about the student's food allergy. This should include the name of the food, notes about the severity and symptoms related to this allergy.

Other Allergies: _____

Allergy Severity: ☐ Annoying ☐ Mild ☐ Moderate ☐ Severe ☐ Life threatening

Please use this space to tell us about any other allergies not related to medication or food, allergy symptoms and severity (annoying, serious or life threatening):

Do any of the above allergies require the use of an EpiPen? ☐ Yes ☐ No If yes, please use this space to tell us about the appropriate use of the student's EpiPen:

Dietary Restrictions/Modifications*: ☐ Celiac ☐ Diabetic ☐ Kosher ☐ Vegan ☐ Vegetarian ☐ Other **JKCP may contact you discuss these dietary restrictions or modifications.*

Please use this space to tell us more about the dietary restrictions listed above:

Surgery or Serious Injuries (Dates) _____

Disability or Chronic Recurring Illness _____

Are there any medical, physical or other conditions that may limit the student's ability to fully participate in any activity. ☐ Yes ☐ No

If yes, please describe:

Has student been in the care of a psychologist or psychiatrist in the past twelve months? ☐ Yes ☐ No

If yes, please describe:

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Keep it in the original package or bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. It will remain the policy of JKCP that prescription medications that are not listed on the medical form will not be allowed on campus. In addition, the amount of medication a student brings to the program should meet, but must not exceed, the proper dosage needed for their stay with us. While at the program, please do not alter their medication routine. Students should continue taking their medication(s) as they normally would at home.

Med #1 Dosage ☐ Requires Refrigeration Schedule

Condition

Med #2 Dosage ☐ Requires Refrigeration Schedule

Condition

Med #3 Dosage ☐ Requires Refrigeration Schedule

Condition

HEALTH INFORMATION FORM

EMERGENCY CONTACT INFORMATION

To be used in the event that the primary and or secondary parent or guardian cannot be reached by telephone.

Name _____

Phone 1 _____ Phone 2 _____ Phone 3 _____

HEALTH OR TRAVELERS INSURANCE INFORMATION

Please use the section below to complete the corresponding information from your insurance card or policy document. We understand not all may apply. You will also be asked to upload a copy of your card or policy document.

Insurance Company Name _____

ID Number: _____ Group Number: _____

Plan Code: _____ Member Number: _____

Insured Name: _____

Payer Number: _____

Member Services Phone Number: _____ Rx Member Services Phone Number: _____

Provider Phone Number: _____

Please use this space to make any general comments about the student's health that may not have been addressed in the questions above.

IMMUNIZATION RECORDS

Health records must address all of the immunizations listed below, and any immunizations missing from the student's records must be addressed by the physician.

STUDENT NAME _____

LAST FIRST

Students are REQUIRED to have the following immunizations*:	**Date**	**No**	**Notes/Dates**
DPT #5 Primary Series: Diphtheria – Pertussis – Tetanus	☐ Yes ____ /____ /____	☐ No	Notes:
Tdap (within last 6 years if student is 14 or older)	☐ Yes ____ /____ /____	☐ No	Notes:
Polio #4 or #5	☐ Yes ____ /____ /____	☐ No	Notes:
MMR #2 or #3 (Measles – Mumps – Rubella)	☐ Yes ____ /____ /____	☐ No	Notes:
HIB (Haemophilus Influenza b) #3	☐ Yes ____ /____ /____	☐ No	Notes:
Hep B #3	☐ Yes ____ /____ /____	☐ No	Notes:
Varicella (VAR) #2	☐ Yes ____ /____ /____	☐ No	Notes:
Meningococcal Vaccine (within last 5 years) ***(Required by all programs at the University of Pennsylvania.)**	☐ Yes ____ /____ /____	☐ No	Notes:

Signature or Stamp of Examining Physician or Nurse Practitioner

Phone Number: _____

Requests for medical or religious exemptions must be accompanied by a letter from Health Care Provider or Clergy.