

Dear Parents,

The following forms must be submitted to the preschool office before your child will be admitted to The Weinstein School/Camp Marie Benator 2012-13 School and Camp Program:

- Master Profile
- Health Form (signed and dated by your doctor's office)
- Sunscreen & Topical Ointment Form
- 3231 Immunization Form (obtained from your doctor's office)
- Food Allergy Action Plan (*if applicable*)

All required forms are included in this packet, with the exception of the 3231 Immunization Form that must be obtained from your child's doctor's office.

**No child will be permitted to attend without all of the above forms on file in our office.**

Completed forms may be submitted:

- In person to the preschool office
- Scan & Email to [preschool.forms@atlantajcc.org](mailto:preschool.forms@atlantajcc.org)
- Fax to 770-396-2472
- Mail to: The Weinstein School  
Marcus Jewish Community Center of Atlanta  
5342 Tilly Mill Road  
Dunwoody, Georgia 30080

If you have any questions, please contact:

- Janice Verner – [janice.verner@atlantajcc.org](mailto:janice.verner@atlantajcc.org), 678-812-3800
- Shannon Gardner – [shannon.gardner@atlantajcc.org](mailto:shannon.gardner@atlantajcc.org), 678-812-3800

THE WEINSTEIN SCHOOL  CAMP MARIE BENATOR  CAMP ISIDORE ALTERMAN JR.

Please complete one per child. Registration forms are also available online at [www.atlantajcc.org](http://www.atlantajcc.org)

MJCCA Membership #	<input type="checkbox"/> HD <input type="checkbox"/> FD	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Synagogue Affiliation
Child's Last Name	First	Middle	Nickname
Birthdate (mm/dd/yyyy)	Age (as of Sept. 1, 2012)	Child lives with <input type="checkbox"/> Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparents <input type="checkbox"/> Guardian	
Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		For Divorced Parents or Legal Guardians:	Who is responsible for payment? Name Who has custody of this child? Name
Parent/Guardian 1 Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Parent/Guardian 2 Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.
Home Address		Home Address	
City	State / Zip	City	State / Zip
Subdivision	County	Subdivision	County
Home Phone #	Fax #	Home Phone #	Fax #
Work Phone #	Cell #	Work Phone #	Cell #
Email address (please print)		Email address (please print)	
Occupation / Business Name	Business Address	Occupation / Business Name	Business Address
Grandparents' Names	Address	Grandparents' Names	Address
May be released to Grandparents <input type="checkbox"/> Y <input type="checkbox"/> N	Phone	May be released to Grandparents <input type="checkbox"/> Y <input type="checkbox"/> N	Phone
<b>EMERGENCY CONTACT. Individuals other than Parents whom we may contact and release child to if parent cannot be reached.</b>			
Name	Relationship	Home Phone _____ Work Phone _____ Cell Phone _____	Address
Name	Relationship	Home Phone _____ Work Phone _____ Cell Phone _____	Address
Allergies: Does your child have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, allergy form must be completed and picture of child attached. If yes, please list allergies:			
Additional Support: Does your child or has your child ever received any medical or educational therapies (PT, OT, Speech, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list therapies: _____ Date of last therapy session: _____			
I understand and give my permission to MJCCA that my child and/or his voice may appear in printed material, photographs or visual and/or audio recordings from the MJCCA.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I give permission for my address, phone numbers and email to be released to other preschool families.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I hereby authorize MJCCA to include my child in supervised water activities (if applicable).			<input type="checkbox"/> Yes <input type="checkbox"/> No
I have read and fully understand the 2012-2013 MJCCA Preschool Policies that are available at <a href="http://www.atlantajcc.org">www.atlantajcc.org</a> .			<input type="checkbox"/> Yes <input type="checkbox"/> No
Authorization For Treatment: Should the need for medical attention arise; (and in case of our unavailability), as parents or legal guardians, we want the MJCCA and/or staff to arrange and authorize medical treatment as necessary for our child, Child's Medical Insurance Co. _____ Group # _____ ID # _____ The MJCCA will use the nearest available hospital. Should specialist advice or treatment be required, our preferences are: Doctor _____ Address _____ Ph _____ Dentist _____ Address _____ Ph _____ In the absence of a parent or guardian, <input type="checkbox"/> I hereby give authorization <input type="checkbox"/> I do not give authorization to the named emergency contact person to have access to my child's health information.			This information is complete to the best of my knowledge.  Parent/Legal Guardian Signature _____  Date _____

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Child's Full Name	Date of Birth
Address	Phone Number

**MEDICAL / IMMUNIZATION INFORMATION** Please, note that Georgia Health Form #3231 is required for all children. Families new to Georgia may provide an official document equivalent to the GA 3231 immunization record. All records must be in English.

Height	Weight	Gender <input type="checkbox"/> F <input type="checkbox"/> M
Chronic Medical Conditions <input type="checkbox"/> Y <input type="checkbox"/> N <small>If Yes, provide details.</small>	Dietary needs or restrictions <input type="checkbox"/> Y <input type="checkbox"/> N <small>If Yes, provide details.</small>	
Medicine or Food Allergies <input type="checkbox"/> Y <input type="checkbox"/> N <small>If so, a completed Allergy Form is required along with this form.</small>	Any regular or PRN medicines <input type="checkbox"/> Y <input type="checkbox"/> N <small>If so, which ones?</small>	

Does Child have any history of:

Vision Impairment or eye infection	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, what? _____
Hearing Impairment or ear infection	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, what? _____
Tubes in ears?	<input type="checkbox"/> Y <input type="checkbox"/> N	
Speech problems	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, what? _____
Rashes	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, what? _____

Are any restrictions on normal physical activities indicated?    Y    N  
If Yes, provide details:

**Physician's Name** (please print)

Physician's Signature	Date
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Physician's Address	Phone
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In the event of an emergency, I hereby give permission to the physician selected by the director or other MJCCA official to order x-rays, routine tests, and treatment for the health of my child. In the event that I cannot be reached in an emergency situation, I hereby give permission for a physician selected by the preschool director or other MJCCA official to hospitalize, secure proper treatment for, and order injections and/or anesthesia and/or surgery for my child.

I authorize any physician, nurse or other health care provider to communicate with the staff and director of MJCCA Preschools, or his/her designee, about my child's medical condition, treatment and/or prognosis. I further authorize the director to discuss any medical conditions with his/her designee, or the child's teacher when the director, in his / her sole discretion, believes such communication to be in the best interest of the child.

I, the parent/legal guardian, assume all risks and hazards incidental to the conduct of activities and transportation to/from the activities. I understand that aspects of the MJCCA preschools & Camps may be physically and emotionally demanding. Both my child(ren) and I agree to follow any and all rules, guidelines, and safety instructions that may be provided by MJCCA staff. I recognize the inherent risk of injury or disability in activities. I understand that each participant must assume the risk of injury or disability that could result from any of these activities. I hereby release, indemnify, defend, save, and hold the MJCCA its officers, directors, trustees, employees, members, agents, and activity providers harmless, with respect to any and all claims or liability for any injury to my child(ren) from participation in any and all Camp activities and all claims by or on behalf of myself, my child(ren), or third parties for loss or damage unless the alleged loss is solely the result of the MJCCA's gross negligence or misconduct.

I give permission for this information on \_\_\_\_\_ to be shared with my child's school.  
(Child's name)

Parent/Legal Guardian Signature	Date
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Parent Name (please print)



# Authorization to Dispense Sunscreen / Bug Spray / Topical Ointment

590-1-1-.20(1) – Georgia Bright From The Start

## Parental Authorization

Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give the Weinstein School/Camp Marie Benator/Camp Isidore Alterman Jr. of the MJCCA permission to apply one or more of the following topical ointments/preparations to my child, \_\_\_\_\_ in accordance with the directions on the label of the container.

- \_\_\_\_\_ Baby Wipes
- \_\_\_\_\_ Band-aids
- \_\_\_\_\_ Neosporin or similar ointment
- \_\_\_\_\_ Bactine or similar first aid spray
- \_\_\_\_\_ Sunscreen
- \_\_\_\_\_ Insect Repellent
- \_\_\_\_\_ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
- \_\_\_\_\_ Baby Powder
- Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\*School will maintain form in child's general file\*

# 3231 IMMUNIZATION FORM

This form must be obtained from your child's doctor's office.

Form **3231** (Rev. 10/01/2005)

Georgia Department of Human Resources  
CERTIFICATE OF IMMUNIZATION

Form **3231** (Replaces Forms 3032 and 3227)

**Lastname, Firstname I.**  
Child's Name (Last name first)

Birthdate

OR  (Fill in X)  
**Date of Expiration**  
 (Next immunization or review of medical exemption due.)  
**Complete For School Attendance**  
 Child must be >= 4 years and have met all requirements for school attendance. The vaccine history section must be filled in.

Parent/Guardian Name (Last name first)

\*Georgia law requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Dates of Immunization ARE required for age 4 years and up. Dates are NOT required before the 4th birthday. See 3231INS and 3231REQ guides relative to Hib

VACCINE	DATE			DATE			DATE			DATE			DATE			Total Doses	Diagnosed	Serology +	History	Med. Exemption
	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY					
DTP, DTaP, DT, Td or Tdap																				
Hepatitis B (Under Age 5)																				
Hib																				
OPV																				
IPV																				
MMR																				
Measles																				
Mumps																				
Rubella																				
Varicella																				

**\*Notes:**  
 A licensed physician or Health Dept. official is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in in the appropriate box(es).  
**The certificate is NOT valid without names of the child and a parent/guardian, date of expiration OR "X" in complete for school box, legible name and address of the physician or health department, certified by signature and a date of issue**  
 A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration.  
**When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility**  
 Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the DHR.

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Dept.  
**Sample Q. Physician, M.D. P.C.**  
**1234 Some Street**  
**Fictitious Town GA 99999-9999**  
**(555) 123-4567**

Certified by (Signature) \_\_\_\_\_ Date of Issue \_\_\_\_\_

# Food Allergy Action Plan

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

Place  
Student's  
Picture  
Here

Extremely reactive to the following foods: \_\_\_\_\_

## THEREFORE:

- If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.  
 If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

### Any SEVERE SYMPTOMS after suspected or known ingestion:

#### One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough  
HEART: Pale, blue, faint, weak pulse, dizzy, confused  
THROAT: Tight, hoarse, trouble breathing/swallowing  
MOUTH: Obstructive swelling (tongue and/or lips)  
SKIN: Many hives over body

#### Or combination of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)  
GUT: Vomiting, crampy pain



### 1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:\*  
-Antihistamine  
-Inhaler (bronchodilator) if asthma

\*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

### MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth  
SKIN: A few hives around mouth/face, mild itch  
GUT: Mild nausea/discomfort



### 1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

## Medications/Doses

Epinephrine (brand and dose): \_\_\_\_\_

Antihistamine (brand and dose): \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if asthmatic): \_\_\_\_\_

## Monitoring

**Stay with student; alert healthcare professionals and parent.** Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician/Healthcare Provider Signature \_\_\_\_\_

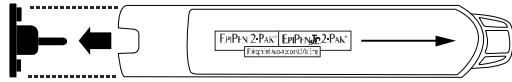
Date \_\_\_\_\_

TURN FORM OVER

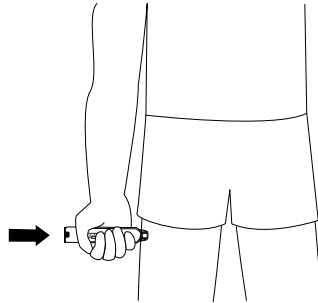
Form provided courtesy of FAAN ([www.foodallergy.org](http://www.foodallergy.org)) 7/2010

### EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds



DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

### Twinject® 0.3 mg and Twinject® 0.15 mg Directions



Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



**SECOND DOSE ADMINISTRATION:** If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.



Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.



### Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."



Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

### Contacts

Call 911 (Rescue squad: ( ) - ) Doctor: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_  
 Phone: ( ) - \_\_\_\_\_

### Other Emergency Contacts

Name/Relationship: \_\_\_\_\_  
 Name/Relationship: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_  
 Phone: ( ) - \_\_\_\_\_