

HILLEL DAY CAMP SUMMER 2008 PROGRAM 389 Central Avenue Lawrence, NY 11559

Camp Health History and Examination Form

This side to be filled in by parents/guardian of minors or by adult campers/staff members themselves.

Name _____ (last) (first) (middle) DOB _____ Sex _____ Age _____

First Parent/Guardian or Spouse:

Name _____ Phone _____

Home Address _____ Cell Phone _____

Business Address _____ Phone _____

Second Parent or Guardian:

Name: _____ Phone _____

Home Address _____ Cell Phone _____

Business Address _____ Phone _____

Emergency contacts:

Name (1) _____ Phone _____

Name (2) _____ Phone _____

Health History: (Check-giving approximate dates)

Frequent Ear Infections _____	Chicken Pox _____	Hay Fever _____
Heart Defect/Disease _____	Measles _____	Ivy Poisoning _____
Convulsions _____	German Measles _____	Insect Stings _____
Diabetes _____	Mumps _____	Penicillin _____
Bleeding/Clotting _____		Asthma _____
Hypertension _____		

Has this camper ever required any psychiatric counseling or hospitalization? _____

Operations or serious injuries (dates): _____

Disability or chronic or recurring illness: _____

Any specific activities to be encouraged or limited by physician's advice: _____

Dietary modifications: _____

Current Medication: (send with instructions) _____

Other diseases or details of above: _____

Name of Dentist/Orthodontist: _____ Phone: _____

Name of Family Physician: _____ Phone: _____

Date of last Physical exam; _____

Family Medical/Hospital Insurance:

Carrier: _____ Policy #: _____

Suggested or health related information for camp personnel: _____

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special Consideration: _____

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine test and treatment for me/or my child, and in the event I can not be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/my child as named above. This form may be photocopied for use outside of camp. I also give permission for routine medical care for my child by the camp.

Signature of Parent /Guardian or Adult camper/staff: _____

Witness: _____ Date: _____

I understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor: _____

If for religious reasons you cannot sign this form, then the camp should be contacted for a legal waiver which must be signed for attendance.

Immunization History: Please give all dates of immunization for:

Vaccine		mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy
DTP							
TD	Tetanus/ Diphtheria						
Tetanus							
Polio							
MMR							
	Or Measles						
	Or Mumps						
	Or Rubella						
Haemophilus Influenza B							
Hepatitis B							
Varicella							

Health Examination by a Licensed Physician:

I have examined the above camper within the past two years. Date Examined:

In my opinion, the above's condition does _____/ does not _____ preclude his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s): _____

Current treatment: (include current medications): _____

Explanation of any reported loss of consciousness, convulsions or concussions: _____

Does applicant have epilepsy? Yes _____ No _____ Does applicant have diabetes? Yes _____ No _____

Recommendation and Restrictions while at Camp:

Any treatment to be continued at camp: _____

Any medication to be administered at camp (specific dosages): _____

Any medication prescribed meal plan or dietary restrictions: _____

Any allergies (food, drug, plant and insects, etc.): _____

Additional Health Information: _____

Licensed Physician's signature and stamp: _____ Phone: _____

Address _____

Date of Form Completion: _____ By: _____