B"H

2018 HEALTH RECORD

CAMP GAN ISRAEL OF ROSLYN

73 Powerhouse Road, Roslyn Heights, NY 11577. Phone: (516) 484-3500 Fax: (516) 484-4922

THIS SIDE OF FORM TO BE COMPLETED BY PARENT OR GUARDIAN

Separate form must be completed for each child

Child's Name: _____ Date of Birth: ____/____/____ Gender: M / F

Address: _____ City, State, Zip: _____

Home Phone: ( )_____

Father's Name: _____ Home Phone (if different): ( )_____

Business Phone: ( ) _____ Cell/Pager#: ( ) _____

Address (if different from above): _____

Mother's Name: _____ Home Phone (if different): ( )_____

Business Phone: ( ) _____ Cell/Pager#: ( ) _____

Address (if different from above): _____

Emergency Name (Friend): _____ Phone: ( ) _____

Emergency Name (Relative): _____ Phone: ( ) _____

Permission to send home to housekeeper? Yes____ No____ Name: _____

Permission to give Tylenol for fever or pain? Yes____ No____

Allergies: _____ If Yes, specify: _____

Existing medical conditions/injuries: _____

Medications/treatments: _____

Special needs/diets: _____

IMPORTANT – This box must be completed for registration – Please sign

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the Director to order X-rays, routine tests, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Director to secure and administer treatment, including hospitalization for my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian: _____ *Date:* _____

Please Print Name: _____ *Relation:* _____

TURN OVER

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THIS SIDE OF FORM TO BE COMPLETED BY PHYSICIAN

(Physician may use his/her own form, provided it includes both physical exam info and immunization history)

Camper's Name: _____Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: Right: _____ Left: _____ Glasses or other appliances: _____

Exam	Normal	Abnormal	Description
Eyes			
Ears			
Nose & Throat			
Neck			
Heart			
Lungs			
Abdomen			
Genitals			
Skin			
Extremities			
Spine			
Neurological			
Other			

Operations/previous illness: _____

Medications: _____

Special conditions: _____

IMMUNIZATION HISTORY

DPaP, DTP or TD: Date _____ Date _____ Date_____ Date _____

Polio: Date _____ Date _____ Date_____ Date _____

MMR: Date _____ Date _____ Date_____ Date _____

HIB: Date _____ Date _____ Date_____ Date _____

Hepatitis B Date _____ Date _____ Date_____ Date _____

Varicella: Date _____ Date _____

Other _____Date _____ Date _____

In my opinion, the above child may___ may not___ participate in all activities.

Limitations: _____

Physician's Signature: _____ Physician Stamp: _____

Physician's Name: _____

Address: _____

Phone: ( ) _____ Date of Exam: _____

Date of exam must be within twelve months of the child's last day attending camp