

**CAMP GAN ISRAEL OF ROSLYN**

210 Forest Drive, East Hills, NY 11548. Phone: (516) 484-3500 Fax: (516) 484-1219

**THIS SIDE OF FORM TO BE COMPLETED BY PARENT OR GUARDIAN**

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: \_\_\_\_\_

# CAMP GAN ISRAEL OF ROSLYN

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## THIS SIDE OF FORM TO BE COMPLETED BY PHYSICIAN

Camper's Name: \_\_\_\_\_

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: _____
<b><i>Date of exam must be within twelve months to the child's last day of attending camp</i></b>	