

Camp Health Examination Record Camp Chomeish Summer 5772 - 2012



To register, fill out all information, one form per child, sign and return/mail with your check or charge to the address below.
PLEASE WRITE CLEARLY (To be completed by parent/guardian)

Camper Information

Name: _____ Sex: **Female** Age: _____ Birth Date: M _____ D _____ Y _____

Street Address: _____ City _____ State _____ Zip _____

In Emergency, **י"ח** Notify: _____ Relationship _____

Address: _____ Home Phone: (_____) _____

Work: _____ Cell: (_____) _____ Beeper: (_____) _____

General Health Record

Height: _____ Weight _____ Date of Exam **▶** _____

Identify any known medical or emotional illness or disorder that would currently pose a risk to other children or which currently affect the child's functional ability to participate safely:

Medical information pertinent to routine childcare and emergencies:

Does the child wet the bed? YES NO If yes how often? _____ per week _____ per month

Other medical information pertinent to routine childcare and emergencies:

Is this child taking prescription medication for an illness/condition? Yes No

If YES ▶▶ Please fill out the Authorization to Administer Medication form

Does the child have allergies? Yes No Explain _____

Is the child on a special diet? Yes No Explain _____

Is this child current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health? YES NO

The above named person is in satisfactory condition and may engage in all camp activities except as noted:

IMMUNIZATION	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE	IMMUNIZATION	DATE
DTP/DTaP/P/DT						MMR 1ST DOSE	
OPV/IPV						MEASLES 2ND DOSE	
HAEMOPHILUS INFLUENZA TYPE B						VARICELLA (Chicken Pox)	
HEPATITIS B						Other (specify)	

Insurance Information

Medical Insurance Co. _____ # _____ Please attach copy of card

Name of policy holder: _____

Authorization

Social Security Number - - (Parent) Date of Birth M _____ D _____ Y _____

▶ Signature of M.D., APRN, LPN or PA or Parent or self if over 18 years old:

Date: M _____ D _____ Y _____ State Licensed in: _____ Lic. # _____

Address _____

PARENT OR GUARDIAN AUTHORIZATION (REQUIRED FOR ALL PERSONS UNDER 18)

This health history is correct so far as I know, and the person named above has permission to participate in all camp activities except as noted by the examining physician or me. If I can not be reached in an emergency, I hereby give permission to the physician selected by the camp director or his designated authorized person to hospitalize, I hereby give permission to the physician selected by proper treatment for and order injection, anesthesia for surgery for the person named above.

▶ Parent or Guardians Signature _____

Date: M _____ D _____ Y _____

Physicians stamp