Camp Health Form

Return to: Arthur M. Glick Jewish Community Center
ATTN: Aaron Atlas
6701 Hoover Road, Indianapolis, IN 46260

Ruach, Masada, Tikvah, Gesher, Arts, Construction, Glee, Sports, Tennis

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Participant Information

Name_____ Birth Date_____ Grade at start of camp_____
Last First Middle

Home Address_____
Street Address City State Zip

Social Security Number of Participant_____ Gender: [ ] Male [ ] Female

Custodial Parent/ Guardian_____ Phone_____

Home Address_____
(if different from above) Street Address City State Zip

Business Address_____
Street Address City State Zip

Custodial Parent/ Guardian_____ Phone_____

Home Address_____
(if different from above) Street Address City State Zip

Business Address_____
Street Address City State Zip

If parents can not be reached in the event of an emergency, please contact:

Name_____

Relationship_____ Phone_____

Address_____
Street Address City State Zip

Insurance Information

Does the camper have medical coverage? _____ Insurance Company Name or Plan Name_____

Company Address_____
Street Address City State Zip

Name of the insured_____ Relationship to participant_____

Social Security number or insurance ID number_____

Parent Authorization: This health history is correct and complete as far as I know. The camper herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for the camper. In the event that In can not be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for camper named above. This completed form may be photocopied for trips away from camp.

Signature of parents/guardian_____Printed Name_____Date_____

Camp Health Form

Health History

The following information must be entered by the parent/guardian or by you primary doctor. The information received in this form, will be used by camp staff in order to provide appropriate care as needed for the camper. Please keep a copy of this form for your records. If any changes are made, please notify the camp director as soon as possible. Please provide as much and as detailed information as possible.

Allergies:

Medical Allergies	List Reaction	Care for reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Food allergies	List Reaction	Care for reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Allergies	List Reaction	Care for reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Daily Medications: Please list all medications be taken on a daily basis by the camper. This should include over-the-counter and nonprescription drugs. Bring enough medication to last through camp. Please keep medication in its original packaging or bottle. The bottle should identify the prescribing physician, name of the medication, dosage, and frequency of administration.

The above mentioned camper does not take any medication on a regular basis. [ ] Yes [ ] No

The above mentioned camper takes the following medications:

Medication One	Dosage and Time(s)	Reason Medication is being taken
_____	_____	_____

Medication Two	Dosage and Time(s)	Reason Medication is being taken
_____	_____	_____

Medication Three	Dosage and Time(s)	Reason Medication is being taken
_____	_____	_____

Attach additional medication on a separate sheet to this form.

Has the camper been taken off or not taking any medication normally taken during the school year? [ ] Yes [ ] No

If yes, what medications?_____

Restrictions. The restrictions below apply to the aforementioned camper

Diet:

Does not eat pork ____ Does not eat Shellfish____ Does not eat Seafood____ Does not eat eggs____ Does not eat red meat____

Does not eat poultry____ Does not eat eggs____ Does not eat diary products____ Does not eat whey products____

Other…Please add_____

Explain any activities that the camper may not participate in. (ie What can not be done, limitations, special adaptations)_____

_____

_____

_____

_____

Camp Health Form

Health Questions: Please explain any questions marked yes.

Has the camper ever,	Yes	No		Yes	No
1. Had any recent injury, illness, or contagious disease?	☐	☐	15. Have a history of bed wetting?.....	☐	☐
2. Had chronic or recurring illness/ condition?.....	☐	☐	16. History of sleepwalking/ night terrors?.....	☐	☐
3. Been hospitalized?.....	☐	☐	17. Had joint problems?.....	☐	☐
4. Frequent ear infections?.....	☐	☐	18. Have frequent headaches?.....	☐	☐
5. Had seizures?.....	☐	☐	19. Been dizzy during or after exercise?.....	☐	☐
6. Have asthma?.....	☐	☐	20. Passed out during or after exercise.....	☐	☐
7. Have/Had High Blood Pressure?.....	☐	☐	21. Had chest pain during or after exercise?.....	☐	☐
8. Have Diabetes?.....	☐	☐	22. Had an eating disorder?.....	☐	☐
9. Been diagnosed with a heart murmur?.....	☐	☐	23. Had emotional difficulties?.....	☐	☐
10. Had a head injury?.....	☐	☐	24. Have any skin problems(rashes/acne)?.....	☐	☐
11. Been knocked unconscious?.....	☐	☐	25. Have an orthodontic device taken to camp?.	☐	☐
12. Have/Has back problems?.....	☐	☐	26. Wears glasses or contacts?.....	☐	☐
13. Had mononucleosis?.....	☐	☐	27. Has problems with constipation/diarrhea?..	☐	☐
14. Had a surgery?.....	☐	☐	28. If female, had abnormal menstrual history?.	☐	☐

Please explain any questions marked yes:_____

_____

_____

_____

_____

_____

Has the camper ever had? ☐ Measles ☐ Chicken Pox ☐ Mumps ☐ German Measles ☐ Hepatitis A ☐ B ☐ C

TB Mantoux Test-------Date of last test_____ Result ☐ Positive ☐ Negative

Please give all immunization dates:

Vaccine:	Dates: Mo/YR	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
Measles	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Haemophilus Influenza B	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____

Additional information about the camper's health, physical and emotional._____

_____

_____

_____

_____

Physician_____Phone_____Address_____

Dentist/Orthodontist_____Phone_____Address_____

Camp Health Form

Health Care Recommendations by a licensed medical professional

I examined the camper on_____BP_____Weight_____Height_____
Date MM/DD/YYYY

In my professional opinion, this camper IS / IS NOT able to participate in an active camp program.

The camper is under my care for_____

_____

_____

_____

Restrictions at Camp

Treatment to be continued at camp_____

_____

Medications to be given at camp (name, dose, times)_____

_____

Medically prescribed diet_____

_____

Known Allergies_____

_____

Limitations or Restrictions at camp_____

_____

Additional information for camp health care staff _____

_____

_____

_____

_____

_____

Signature of licensed medical professional_____

Printed_____ Title_____

Address_____ Date_____

Phone_____ Fax_____