

2009 Jewish Girls Retreat Health and Medical Form

2155 13th St. Troy, NY 12180

Phone: 518.833.0704 / 518.727-9581

Note to Parents: Please attach a copy of the front and back of your health insurance card

A completed medical form is required. Please mail your completed form by June 1, 2009. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. **Bring medications to check-in to be reviewed by nurse.** Any changes to this form should be reported to camp health personnel upon arrival.

To be completed by Parent or Guardian:

Name _____ Sex _____ Age _____ DOB ____/____/____
 Home Address _____ City _____ State _____ Zip _____
 Custodial Parent/Guardian _____ Home Phone _____ Work Phone _____ Cell _____
 Other Parent/Guardian _____ Home Phone _____ Work Phone _____ Cell _____
 In emergency, notify _____ Relationship _____
 Address _____ Phone (____) _____
 Work Phone _____ Cell Phone _____
 Insurance Co. _____ Policy Holder _____ Policy # _____

Health History

(check)	other _____	Foods (specify) _____	Heart _____
Chicken pox _____	<u>Allergies</u>	<u>Chronic/recurring illness</u>	Stomach _____
German measles _____	Hay fever _____	eye problems _____	Epilepsy _____
Whooping cough _____	Asthma _____	Earaches _____	Rheumatic fever _____
Measles _____	Ivy, oak, etc. _____	Sinus _____	Diabetes _____
Mumps _____	Insect sting _____	Throat problems _____	Menst. problems _____
	Drugs (specify) _____	Infections _____	

Details of any of the above _____

Medications being taken (name and explain): _____

Operations, injuries, special restrictions (explain, give dates): _____

Health History: The parent/guardian must fill out the following information.

General Questions (Explain "yes" answers below.)

Has/does the participant.....**Yes**.....**No**

1. Had any recent injury, illness or infectious disease?
2. Have a chronic or recurring illness/condition?
3. Ever been hospitalized?
4. Ever had surgery?
5. Have frequent headaches?
6. Ever had a head injury?
7. Ever been knocked unconscious?
8. Wear glasses, contacts or protective eyewear?

9. Ever had frequent ear infections?
 Has/does the participant..... **Yes**..... **No**
10. Ever passed out during or after exercise?
11. Ever been dizzy during or after exercise?
12. Ever had seizures?
13. Ever had chest pain during or after exercise?
14. Ever had high blood pressure?
15. Ever had problems with joints (e.g. knees, ankles)?
16. Have an orthodontic appliance being brought to camp?
17. Have any skin problems (e.g. itching, rash, acne)?
18. Have diabetes?
19. Have asthma?
20. Had mononucleosis in the past 12 months?
21. Had problems with diarrhea/constipation?
22. Have problems with sleepwalking?
23. If female, have an abnormal menstrual history?
24. Have a history of bed-wetting?
25. Ever had an eating disorder?
26. Ever had emotional difficulties for which professional help was sought?-----.....?
27. Have known allergies?
28. Have ADD/ADHD or other learning disabilities?

Please explain any “yes” answers, noting the number of the questions.

NOTE: • Please write or call the camp if your child is exposed to or has contracted any potentially serious communicable disease such as chicken pox, hepatitis, meningitis, etc. during the three weeks prior to camp attendance.

Parent or Guardian Authorization - Permission to Provide Necessary Treatment or Emergency Care:
 This health history is correct and complete as far as I know, and the person named above has permission to participate in all camp activities except as noted by me or the examining physician. I hereby give permission to the medical personnel selected by the camp directors to administer medications, order x-rays, routine tests, hospitalize, secure proper treatment for, order injection, anesthesia for surgery; to release any records necessary for insurance purposes for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian

Signature_____

Date_____

Physical Examination - to be completed by a licensed physician

(1-satisfactory; 2-not satisfactory; 3-not examined)

Height _____	Eyes: _____	Ears: _____	Throat _____	Abdomen _____
Weight _____	Glasses _____	Hearing left _____	Teeth _____	Genitalia _____
BP _____	Contacts _____	Hearing right _____	Heart _____	Hernia _____
Skin _____	Required _____		Lungs _____	Extremities _____
Nose _____	Condition _____		Skeletal _____	

Tests:

Urinalysis glucose _____ Albumin _____ Tuberculin Testing (type) _____ Blood Count (if applicable) _____

Restrictions, limitations, (including diet): _____

Medications: _____

Recommendations: _____

Additional information for health care staff at the camp _____

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

I have examined the above camp participant. Date of last examination _____

BP _____ Weight _____ Height _____

Immunizations:

	diphtheria	tetanus	pertussis	polio	measles	mumps	rubella	other
Date:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Booster:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Medications:

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely.

The following non-prescription medications may be stocked in the camp Health Center and are used as needed to manage illness and injury. Cross out those the camper should NOT be given:

- | | |
|---------------------------------|----------------------------|
| Tylenol | Advil Motrin |
| Sudafed PE | Cough Syrup |
| Sudafed | Generic Cough Drops |
| Antihistamine/ Allergy Medicine | Antibiotic Cream |
| Benadryl | Laxatives for Constipation |
| Sore Throat Spray | Aloe |
| Lice Shampoo or Cream | Pepto Bismal |
| Calamine Lotion | |

Signature of Licensed Medical:

Date: _____ Examining physician: _____
Telephone: _____ Print physician's name: _____
State licensed in: _____ License number: _____ Address: _____