B"H

CAMP GAN ISRAEL OF ORLANDO

Please complete the entire form and print neatly.

Name of Camper _____ Boy ___ Girl ___ Age ____
last first

Week of camp attending: ____ 1st ____ 2nd ____ 3rd ____ 4th Late Stay _____

Previous camp experience _____

Does your child swim? Yes ___ No ___ Does child have fear of water? Yes____ No ___

Swim Level: List most recent American Red Cross Card child earned, date and place:

_____

Name of public/private school now attending _____

Name of synagogue affiliated with _____

Jewish Education: Type of program (after school, day school, nursery or Sunday school),
Years attended _____

Please list brothers and sisters:
Name _____ Age ___ Name _____ Age ___ Name _____ Age ___

Father's Jewish Name _____ Mother's Jewish Name _____

Any information or comment about special talents, habits, behavior or other:

_____

T- Shirt Size _____ Amount _____ @ $6 each. (added to tuition)

Please list 2 emergency contacts:
Name_____ Phone_____
Name_____ Phone_____

B"H

For Office Use

Year

Bunk

Name

Dates of Camp Attendance_____

Mail this form to the address below by May 30 -
(April 10 for early bird special)
PO Box 690282
Orlando, FL 32869-0282 or fax to: 1877.835.6090

Health History Form for Children, Youth and Adults Attending Camps

Developed and approved by the
American Camping Association®
with the American Academy of Pediatrics.

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Name _____ Birth date _____ Age at 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

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business Address _____ Phone _____
Street address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group # _____

▶**Photocopy of front and back of health insurance card must be attached to this form.**

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person 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 treatment, referral billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photo-copied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Printed Name_____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.
Signature of minor or adult camper/staffer _____ Date _____

Important - These boxes must be complete for attendance*

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____
_____ _____

Food allergies (list)

_____ _____
_____ _____

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

_____ _____
_____ _____

B"H

MEDICATIONS BEING TAKEN
RESTRICTIONS (The following restrictions apply to this individual.)

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

☐ This person **takes NO medications** on a routine basis. OR ☐ This person **takes medications** as follows:
Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer:
_____

Does not eat: ☐ Red meat ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe)_____
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)
_____
_____

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	16. Ever had back problems?	☐	☐
2. Have a chronic or recurring illness or condition?	☐	☐	17. Ever had problems with joints? (e.g. knees, ankles)?	☐	☐
3. Ever been hospitalized?	☐	☐	18. Have an orthodontic appliance being brought to camp?	☐	☐
4. Ever had surgery?	☐	☐	19. Have any skin problems? (e.g. itching, rash, acne)?	☐	☐
5. Have frequent headaches?	☐	☐	20. Have diabetes?	☐	☐
6. Ever had a head injury?	☐	☐	21. Have asthma?	☐	☐
7. Ever been knocked unconscious?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
9. Ever had frequent ear infections?	☐	☐	24. Have problems with sleepwalking?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	25. If female, have an abnormal menstrual history?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐	26. Have a history of bed-wetting?	☐	☐
12. Ever had seizures?	☐	☐	27. Ever had an eating disorder?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	28. Ever had emotional difficulties for which professional help was sought?	☐	☐
14. Ever had high blood pressure?	☐	☐			
15. Ever been diagnosed with a heart murmur?	☐	☐			

Please explain any "yes" answers, noting the number of the questions. _____
_____

Which of the following has the participant had?
☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test
Date of last test _____
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

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

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. _____
_____
_____

Name of family physician _____ Phone _____
Address _____ Phone _____
Name of family dentist/orthodontist _____ Phone _____
Address _____

Screening Record ***(For camp use only)*** Screened by _____

Date Screened _____ Time _____ am pm Updates/additions to health history noted ☐ Yes ☐ No ☐ None required
Meds received _____
Current health needs identified _____
Observational notes _____
_____