GAN ISRAEL SUMMER CAMP
Health Exam / Emergency Contact Form

CAMPER _____
STAFF _____

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

Campers will NOT be allowed to participate if completed form is not on file PRIOR to the first day of camp.

Camper's Name _____ Date of Birth _____

Parent/Guardian _____ Daytime Phone _____

Place of Parent's Work _____ Weeks Attending Camp 1 2 3 ALL

Emergency Contact #1(other than parent/guardian) _____ Daytime Phone _____

Emergency Contact #2 (other than parent/guardian) _____ Daytime Phone _____

Permission to Provide Necessary Treatment of Emergency Care:

I hereby give permission to the Gan Israel of NWBC Camp Director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency,I hereby give permission to a physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above.

Parent/Guardian Signature _____ **Date** _____

THIS SECTION TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

This examination is for determining fitness and endurance to engage in potentially strenuous activities.

Date of Exam ____/____/____

_____ May participate in all camp activities.

_____ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

_____

Does the individual have any allergic reaction to: _____ Bees _____ Medication _____ Food _____ Other (describe below)

What symptoms occur: _____

Is this individual taking perscription or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate medications*:

_____

**Medication Authorization form must be on file before individual can participate in camp activities.*

Does the individual carry an epi-pen*? _____ If so, one must be provided to camp. A second epi-pen is required if the individual is in AM or PM Care. **Medication Authorization form must be on file before individual can participate in camp activities.*

Does the individual have special needs? ☐ YES ☐ NO Explain: _____

Does the individual have: _____ ADD/ADHD _____ Asthma _____ Diabetes _____ Other

This individual is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No		Yes	No
Measles			Chickenpox			Diphtheria		
Mumps			Tetanus			Pertussis		
Rubella			Hepatitis B			Polio		

Physician Authorization:

I have examined the individual herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in an active camp program, unless otherwise noted above.

Physician's Name (printed) _____ Date _____

Signature of Examining Physician _____ Phone _____

Address _____

Mail to: Gan Israel, P.O. Box 63, Franklin Lakes, NJ 07417 Fax: 201-848-0559 Ph: 201-848-449 www.ganisraeldaycamp.com