Beth Sholom Day Camp
MEDICAL REPORT

Family Information

Camper Name ______________________ **Phone (Home)** (____) ______________________

Birth Date ___/___/____Age________Sex M / F__ **Phone (Office)** (____) ____________ x_____

Parent/Guardian ______________________ **Phone (Cell)** (____) ______________________

Home Address ____

If you are not available in an emergency, whom shall we notify?

Name ______________________ ______________________

Phone (Home) (____) ______________________ (____) ______________________

Relationship ______________________ ______________________

Health History

Circle any applicable conditions and elaborate in spaces provided below or on another sheet if more room is needed.

1. Headaches, Head Injuries
2. Seizures, Fainting
3. Visual Problems
4. Ear/Sinus Infections
5. Hearing Loss, Hearing Aids
6. Dental Problems, Braces, Caps
7. Diabetes/Hypoglycemia
8. Asthma, Respiratory Disease
9. Heart Murmur, Heart
10. High or Low Blood Pressure
11. Hernias
12. Gastrointestinal Disorders
13. Kidney, Genital, Urinary Disorder
14. Past/Recent Fractures, Sprains
15. Muscular, Bone, Arthritic Disorders
16. Skin Conditions
17. Anemia/Bleeding Tendencies
18. Chicken Pox Date ________
19. Recent Communicable Diseases
20. Mononucleosis in Past (3) Months
21. Behavior Problems, Adjustment Reactions
22. Coordination Problem, Learning Disabilities
23. Food Allergies
24. Other

Medications taken on a regular basis ______________________

Allergies, Drug Sensitivities ______________________

Details of conditions circled above ______________________

Dentist's Name ______________________ Phone ______________________

Parent's Authorization

This health history is up to date and current. The person herein has permission to engage in all prescribed activities except as noted by me and the examining physician. I give permission for the nurse selected by the Camp Director to administer nursing care and first aid to my child as necessary.

Signed ______________________ Date______________

In the event I cannot be reached in a true EMERGENCY I give permission to the physician selected by the Camp Director to hospitalize, order appropriate diagnostic tests, and secure proper treatment as may be deemed necessary for the welfare of the child named above.

Signed ______________________ Date______________

In the event the nurses cannot reach you by telephone, and your child has: 1) Temperature above 101ºF, 2) A headache, 3) An earache; Do you give permission for the nurse to administer an age appropriate dose of Tylenol to your child: Check ONE: ☐ Yes ☐ No

Signed ______________________ Date______________

Immunization History

DTP Series (3 or more doses) ___/___/___ ; ___/___/___ ; ___/___/___ Booster ___/___/___

Polio ___/___/___ ; ___/___/___ ; ___/___/___ Booster ___/___/___

Measles Vaccine ___/___/___ ; ___/___/___ Mumps Vaccine ___/___/___ Rubella Vaccine ___/___/___

Haemophilus Influenza Type B ___/___/___ Hepatitis B ___/___/___ Varicella (Chicken Pox) ___/___/___

Medical Examination

B.P. ____________ Pulse ____________ Height ____________ Weight ____________

Please ✓ for Satisfactory or X for Not Satisfactory

Eyes and Vision _____ HGB/Urinalysis _____ Ears, Nose & Throat _____ Genitourinary _____

Mouth & Teeth _____ Musculoskeletal _____ Lungs _____ Neurological _____

Skin _____ Abdomen _____ Emotional Status _____ Heart & Vascular _____

Learning Disabled (please explain) ______________________

Comments on the above, Recommendations, Restrictions, Special Diet: ______________________

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Physician's Report

Note To Physician - Camper May NOT Start camp Until This Form Is Received

I have reviewed the health history on this form and after conducting an examination find:

______ No limiting conditions. Physically qualified for participation. ______ Limiting conditions as noted above.

Examining Physician (Print) ______________________ M.D.

Signature and Stamp ______________________ Date______________

Address ______________________ Phone______________