



Camper's Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Second Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Health-Care Providers:**

Name of Camper's primary doctor(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone: \_\_\_\_\_

May the camp contact your child's health care providers? \_\_\_\_\_

**Allergies:**

No known allergies

Allergic to: \_\_\_\_\_

Medication: \_\_\_\_\_

Food: \_\_\_\_\_

Insect: \_\_\_\_\_

Latex: \_\_\_\_\_

Others: \_\_\_\_\_

EpiPen for: \_\_\_\_\_

Provide instructions:  
\_\_\_\_\_

**Physical Health**

**History:**

Check all that apply.

<input type="checkbox"/> Asthma- <b>Provide action plan from your physician</b>	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Diarrhea, Constipation	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Back problems	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Immunodeficiency
<input type="checkbox"/> Bleeding, Clotting	<input type="checkbox"/> Joint Problems (ankles, knees)
<input type="checkbox"/> Chest Pains, Dizzy, Passing out	<input type="checkbox"/> Mono, in the last 12 months
<input type="checkbox"/> Diabetes- <b>provide plan &amp; prescription from your physician</b>	<input type="checkbox"/> Seizures, Convulsions
	<input type="checkbox"/> Shortness of Breath, Wheezing
	<input type="checkbox"/> Skin Problems
	<input type="checkbox"/> Sleep Walking
	<input type="checkbox"/> Thyroid Condition

**Mental, Emotional, and Social Health:** Has the child been diagnosed with any of the following:

ADD/ADHD       Depression       Eating Disorder       Learning/Processing

Obsessive-compulsive       Panic, Anxiety       Substance/Abuse       Others: \_\_\_\_\_

Has the camper had a significant life event that continues to affect his/her life? (death, divorce, abuse, adoption...)

If the camper has seen a health professional in the past 12 months, please email the camp so the camp can contact you in regard to services.

**Parent/Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the health care providers selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the health care provider to hospitalize, secure proper treatment for, and order injection anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

**Signature of Custodial Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Relationship to camper:** \_\_\_\_\_



# CONSENT TO TREAT MINORS & INSURANCE INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Primary Insurance Card

### Front of Card

Please confirm that  
all data is legible

## Primary Insurance Card

### Back of Card

Please confirm that  
all data is legible

Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_

#### MENINGOCOCCAL VACCINATION:

State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper or minor staff member who attends camp for seven (7) or more nights. CHECK ONE BOX BELOW.

My Child had the meningococcal meningitis immunization (Menomune™) within the past 10 years.  
Date received: \_\_\_\_\_  
[Note: The vaccine protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

I have read or have had explained to me the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

I give permission for my son/daughter to carry and self-apply sunscreen and insect repellent  
 My son/daughter is unable to apply sunscreen/insect repellent by him/herself. I give permission for the camp staff to assist in the application

#### IMPORTANT - THIS FORM MUST BE COMPLETED IN ORDER FOR YOUR CHILD TO ATTEND CAMP

I the undersigned, Parent/guardian of the above noted minor, do hereby authorize the administration of Mesivta Aliyah as my agent to consent to any diagnostic procedure or medical care which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician and/or surgeon at a hospital or doctor's office. I give permission to the physician selected by the camp to order x-rays, routine tests, and I give permission to the physician selected by Mesivta Aliyah administration to hospitalize, secure proper treatment for, order injections, order anesthesia, or order surgery for my child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to reproduce this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. This authorization shall be in effect until the end of the Summer Camp Season 2025 or until it is revoked in writing and such revocation is delivered to the Mesivta Aliyah office via certified mail.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number



PHYSICIAN'S  
EXAMINATION FORM

Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_

TO BE COMPLETED BY PATIENT'S PHYSICIAN

IMMUNIZATION HISTORY:

\*IMMUNIZATIONS MUST BE CURRENT. Immunization forms from state governments are acceptable for immunization history only.

	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Month/Year
Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox)						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test:	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive			

PHYSICAL EXAM:

Examination Date: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_

Head: \_\_\_\_\_ Eyes/Ears/Nose/Throat: \_\_\_\_\_

Cardiovascular: \_\_\_\_\_ Lung: \_\_\_\_\_ ABD: \_\_\_\_\_

Extremities: \_\_\_\_\_ GU: \_\_\_\_\_ Neuro: \_\_\_\_\_

Patient has the following allergies: \_\_\_\_\_

Patient has the following medical condition: \_\_\_\_\_

In my opinion, patient can participate in all camp activities. YES/NO      If NO, please specify: \_\_\_\_\_

Allergies: \_\_\_\_\_

I authorize standard over the counter medications to be administered as indicated on this form.

Physicians Signature: \_\_\_\_\_ / \_\_\_\_\_

License No.: \_\_\_\_\_

Date: \_\_\_\_\_

NON-PRESCRIPTION  
MEDICATIONS:

THE FOLLOWING MEDICATIONS, OR OTHERS IN  
THEIR CLASS, ARE ACCEPTABLE FOR  
ADMINISTRATION EXCEPT AS NOTED BELOW:

- Acetaminophen (Tylenol)
- Aleve
- Aloe
- Anti-fungal cream
- Antibiotic Cream
- Antibiotic Ointment
- Antihistamine/allergy medicine
- Bismuth Subsalicylate
- Calamine lotion
- Claritin (Loratadine)
- Dextromethorphan
- Diphenhydramine antihistamine (Benadryl)
- Dramamine
- Generic cough drops
- Guaiifenesin
- Hydrocortisone 1%
- Ibuprofen
- Laxatives for constipation
- Lice shampoo or cream
- Mylanta/Maalox
- Simethicone (anti gas)
- Sore throat spray
- Sudafed (Pseudoephedrine decongestant)
- Sudafed PE (phenylephrine decongestant)
- Tums (calcium carbonate)
- Visine
- Other: \_\_\_\_\_

PRESCRIPTION  
MEDICATIONS:

- Patient will not take any daily medications while attending camp
- Patient will take the following daily medication(s) while at camp

Medication/Dose/When to be taken

## **Medications**

Is your child currently taking any medications?

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Please list medications and reasons:

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Prescribing Doctor:

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Prescribing Doctor phone number:

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***Please include a prescription from the doctor.***