HAMESIVTA KOL ARYEH
a division of Camp Degel HaTorah

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

___Camper ___Staff

Name:_____ Date of Birth: _____

Parent/Guardian:_____ Phone: _____

Address:_____ City:_____ State _____ Zip _____

Emergency Contact :_____ Phone_____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

Date Of Last Exam _____/_____/_____ (Physical Exams Are Valid For 3 Years From Date of Last Examination)

___ May participate in all camp activities

___ May participate except for_____

Medical information pertinent to routine care and emergencies_____

_____

Is this individual taking prescription or over the counter medication(s)? ___YES ___ NO

If yes, indicate names of medication(s): _____

Does the individual have allergies? ___YES ___ NO Explain**:** _____

Is the individual on a special diet? ___YES ___ NO Explain**:** _____

Does the individual have special needs? ___YES ___ NO Explain: _____

This camper/staff 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.

	Y	N		Y	N		Y	N		Y	N		Y	N
Measles			Hepatitis B			Rubella			Tetanus			Polio		
Pneumococcal conjugate			Chickenpox			Diphtheria			Mumps			Pertussis		

Comments:_____

_____

Medical Care Provider Information

Name_____ Phone:_____

Address_____ City_____ State _____ Zip Code_____

Signature of Physician, PA, APRN or RN _____ Date _____