

DR.'S PRINTOUT IS NOT SUFFICIENT. DR. MUST SIGN AND STAMP THIS FORM

CAMP TORAS CHAIM TASHBAR



MEDICAL FORM - DUE BY MAY 1, 2026

PAGES 1 & 2 MUST BE FILLED OUT COMPLETELY AND SUBMITTED TOGETHER. PARTIAL SUBMISSIONS (one page without the other) OR INCOMPLETE PAGES WILL NOT BE ACCEPTED.

Last Name First Name Birth Date Address City/State/Zip Phone

1. IMMUNIZATION HISTORY

ALLERGIES

MEDICAL HISTORY

Table with columns for Immunization History, Allergies, and Medical History. Includes rows for DPT/DT, TETANUS, ORAL POLIO, MMR, PPD/MANTOUX, HEPATITS A, MENINGITIS, INFLUENZA TYPE B, and various allergies like PENICILLIN, SULFA, CEPHALOSPORIN, etc.

*If you or your doctor objects to this vaccine please see the back of this form. Signature required.

2. PHYSICAL EXAM

Physical Exam section with fields for Height, Weight, B.P., Glasses/Lenses Prescription, Operations, Serious Injuries, Fractures etc., Chronic or Recurrent Illness and Suggested Treatment, Special Restrictions, and a note to detail any special circumstances.

3. OVER THE COUNTER/PRN MEDICATIONS to be self-administered at the discretion of the camp medical director (SIGNATURES REQUIRED ON THIS FORM. Doctor: Sign below. Parent: Sign on page 2)

Table for Over-the-Counter/PRN Medications with columns for Drug, Route, Dosage, Schedule, and Contra-Indicated/Comments. Lists medications like Acetaminophen, Ibuprofen, Robitussin, Dramamine, Benadryl, Sudafed, Tums, Cortisone Ointment, and Antifungal Ointment.

DOCTOR MUST SIGN AND STAMP THIS FORM AUTHORIZING USE OF 'OVER-THE-COUNTER' MEDICATIONS

SIGNATURE AND STAMP OF EXAMINING PHYSICIAN:

ADDRESS: PHONE: DATE:



DR.'S PRINTOUT ACCEPTABLE FOR PARTS 1 & 2 ONLY, DOCTOR MUST STILL SIGN AND STAMP THIS FORM

DOCTOR MUST SIGN

MENINGITIS VACCINE OBJECTION Please check this box if you object to the meningitis vaccine

* I have read and understand the enclosed material on the harmful effects & risks associated with Bacterial Meningitis and the benefits of immunization. By checking the box, I note my objection to the Meningococcal Meningitis Vaccine.

OVER THE COUNTER MEDICATIONS

Please Check one: I hereby allow do not allow my son to take the over-the-counter medications, listed on page 1 of this form, under the medical director's supervision, unless contra-indicated.

EMERGENCY INFORMATION

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM HIS PARENTS

We, the undersigned, parent(s) of _____, a minor, do hereby
(First Name) (Last Name)
authorize CAMP TORAS CHAIM TASHBAR and/or Rabbi Alexander Dembitzer, Director, as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician and surgeon at Catskill Regional Medical Center.

It is understood that this authorization is given in advance of any specific need for treatment but it is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.

We also hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of our child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp administration to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for our child named above.

This authorization shall remain effective until August 31, unless sooner revoked in writing delivered to said agent(s).

Parent/Guardian Name _____ **Date** _____
(Last Name) (First Name)



Home Phone # _____ **Cell Phone #** _____

Parents' Emergency Phone # _____

Other Emergency Contact: (Name) _____ **Phone #** _____

PARENT/GUARDIAN SIGNATURE _____



MEDICAL AND PRESCRIPTION DRUG INSURANCE INFORMATION

Please make copies of your medical and prescription insurance cards and paste in the boxes below. If you do not have insurance coverage in New York State or if insurance information is not attached, please provide credit card information below to pay for all medical costs.

Medical Insurance: _____ Policy number: _____

PASTE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD HERE

I do not have medical insurance.

PASTE A COPY OF THE FRONT OF YOUR PRESCRIPTION DRUG CARD HERE

My medical coverage is the same, a copy of my card is already attached.

I do not have drug coverage.

CREDIT CARD INFORMATION: Name: _____ Credit Card# _____

Visa and Mastercard only

Exp. Date _____ Signature _____