

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

CAMP TORAS CHAIM TASHBAR



MEDICAL FORM

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 _____

IMMUNIZATION HISTORY			ALLERGIES			MEDICAL HISTORY	
	Date Basic Series Completed	Most Recent Booster		Yes	No	Comments	Indicate Date of Illness
DPT/DT			PENICILLIN				CHICKEN POX
TETANUS			SULFA				MEASELS
ORAL POLIO			CEPHALOSPORIN				GERMAN MEASELS
MMR			OTHER MEDS				MUMPS
PPD/MANTOUX			FOODS (LIST)				HEPATITIS
HEPATITIS A			BEEES/INSECT BITES				PNEUMONIA
MENINGITIS *							Diabetes _____
INFLUENZA TYPE B							Seizures _____
							Asthma _____

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

PHYSICAL EXAM

Height _____ Weight _____ B.P. _____ Glasses/Lenses Prescription _____
 Operations, Serious Injuries, Fractures etc.: _____
 Chronic or Recurrent Illness and Suggested Treatment: _____
 Special Restrictions: (Diet or other activities – please specify) _____
 Please detail any special circumstances or conditions that our staff should be aware of that will assist us in the care of your child, (e.g. frequent colds, headaches, stomach aches, anxiety reactions, etc.) and what you recommend as treatment.
 PLEASE NOTIFY CAMP IF CHILD WAS EXPOSED TO ANY COMMUNICABLE DISEASES DURING THE 3 WEEKS PRIOR TO CAMP. IF CHILD HAS A CHRONIC OR ACUTE MEDICAL CONDITION, IT IS IMPERATIVE THAT THE CAMP BE NOTIFIED.

DR.'S PRINTOUT MAY BE ATTACHED, HOWEVER, DOCTOR MUST STILL SIGN THIS FORM BELOW

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)

DRUG (or generic equivalent)	ROUTE	DOSAGE	SCHEDULE	CONTRA-INDICATED (Check only if medication is not to be given)	COMMENTS
Acetaminophen	PO	Per Label Instructions by age/weight	q 6hr prn for discomfort or elevated temp		
Ibuprofen	PO	Per Label Instructions by age/weight	q 4hr prn for discomfort or elevated temp		
Robitussin	PO	Per Label Instructions by age/weight	q 4hr prn for cough		
Dramamine	PO	Per Label Instructions by age/weight	½ hr before embarkation		
Benadryl	PO	Per Label Instructions by age/weight	q 6hr prn for allergic reaction		
Sudafed	PO	Per Label Instructions by age/weight	q 6-8hr for nasal congestion/drainage		
Tums	PO	Per Label Instructions by age/weight	q 30 min prn for gastric upset/heartburn		
Cortisone Ointment	TOP	Per Label Instructions by age/weight	As indicated		
Antifungal Ointment, Spray	TOP	Per Label Instructions by age/weight	As indicated		

DOCTOR MUST SIGN

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

SIGNATURE AND STAMP OF EXAMINING PHYSICIAN: _____
 ADDRESS: _____ PHONE: _____ DATE: ____/____/____

DR. SIGN HERE

PARENT SIGNATURE ON PG 2

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 _____