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

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CAMP TORAS CHAIM TASHBAR

MEDICAL FORM - DUE BY MAY 15

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			CEPHALOSPO RIN				GERMAN MEASELS	
MMR			OTHER MEDS				MUMPS	
PPD/MANTOUX			FOODS (LIST)				HEPATITIS	
HEPATITS A			BEES/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		
Robitussen	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

DR. SIGN HERE

SIGNATURE AND STAMP OF EXAMINING PHYSICIAN: ____________________

ADDRESS: ____________________ PHONE: ____________________ DATE: ______/______/_______

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______________________________