בס"ד

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

# CAMP TORAS CHAIM TASHBAR

## MEDICAL FORM - DUE BY MAY 1st – (PG. 1)

**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**

| | 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 (must list 2) | 1) | 2) | 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.

**2. 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 ACCEPTABLE FOR PARTS 1 & 2 ONLY, DOCTOR MUST STILL SIGN AND STAMP THIS FORM**

**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)

| **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 AND STAMP THIS FORM** AUTHORIZING USE OF 'OVER-THE-COUNTER' MEDICATIONS

**SIGNATURE AND STAMP OF EXAMINING PHYSICIAN:** ________________________________________ **DR. SIGN AND STAMP HERE**

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______________________