Taste of Gesher 2017 Medical Form

STANDARD CONFIDENTIAL HEALTH HISTORY

Instructions: Complete this health report before camper arrives at camp.

PATICIPANT INFORMATION

Name ____ Email ________________

Date of Birth _____/_____/_____ Sex _____ Age _____
day mo year

Address: ____

City: __________________ Postal Code _____________ Phone: (___) _____-__________

Health Card No.: ______________________________ Version Code _________________

Other Health Insurance: ____

Parent/Guardian Name: ____

Address: (if different from above) ____

City: _________________________________ Postal Code _____________________

Phone (H): (____) _______-____________ Phone (B): (____)_______-____________

Emergency Contact: Name ______________________ Relationship _________________

Address: ____

City: ________________________________ Postal Code ___________________________

Phone (H): (____) _______-____________ Phone (B): (____) _______-____________

HEALTH HISTORY

ALLERGIES

Drugs: ____
Food: ____
Insect Stings or Bites: ____
Seasonal Allergies (i.e. Hay Fever): ____
Other: ____
Reactions: ____
Carries Ana-Kit: ☐ Yes ☐ No Carries Epi-Pen: ☐ Yes ☐ No

RECENT ILLNESS, OPERATIONS or INJURIES: _______________________________
____

PAST HISTORY OF COMMUNICABLE DISEASES AND APPROXIMATE DATES:
Chicken Pox ____________________ Hepatitis _____________________
Whooping Cough ________________

Other ____

OTHER HEALTH ISSUES: (Please check any applicable areas)

- ☐ Asthma
- ☐ Bedwetting
- ☐ Behavioral Concerns
- ☐ Clotting Disorders
- ☐ Dental Appliances
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Eye Glasses/Contacts
- ☐ Emotional/Physical Limitations
- ☐ Frequent Colds/Sinus Trouble
- ☐ Frequent Earaches/Infections
- ☐ Headaches
- ☐ Hearing Aids
- ☐ Hearing Difficulties
- ☐ Heart Disease/Defect
- ☐ Homesickness
- ☐ Hypertension
- ☐ Nightmares
- ☐ Seizure Disorders
- ☐ Skin Conditions
- ☐ Sleepwalking
- ☐ Urinary Tract Infection
- ☐ Vision Difficulties

MEDICATIONS BEING SENT: (If you need more space, please write on the back)

	Medication Name	Dosage	Administration Times	Reason for Taking
1.	____________________	__________	__________________	__________________
2.	____________________	__________	__________________	__________________
3.	____________________	__________	__________________	__________________

All medications must be in original containers and clearly labeled.

DIETARY RESTRICTIONS or CHOICES: ____
____

SPECIFIC ACTIVITIES TO BE ENCOURAGED OR LIMITED: __________________________
____

AUTHORIZATION

To the best of my knowledge, this camper does not have a communicable disease, has not been in contact with anyone who has a communicable disease within 3 weeks of the camp session start date, and is physically able to participate in all camp activities except as indicated. All medical problems, or conditions requiring ongoing medical supervision or care, have been fully noted. I give permission for this health information to be shared with the appropriate camp staff and outside medical personnel as necessary. If the parent/s cannot be reached, permission is, hereby, given to the camp staff to take whatever steps it deems necessary to ensure the safety and health of the camper. This also allows permission for the camp to contact the camper's family physician/specialist.

I, hereby, certify that all information completed in this form is accurate and up to date. I will contact the camp, in writing, if changes occur in camper's health status between now and arrival at camp.

Parent/Guardian Name: ____________________________________

Signature ____________________________________

Date: ____________________________________