



THIS PROGRAM IS SPONSORED BY
UJA Federation
 OF GREATER TORONTO



Camp Geshher

**Taste of Geshher 2018
 MEDICAL FORM**

STANDARD CONFIDENTIAL HEALTH HISTORY

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

PATICIPANT INFORMATION

Name _____

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

Address: _____

City: _____ Postal Code _____ Phone: (____)____-_____

Health Card No.: _____ Version Code _____

Other Health Insurance: _____

Parent/Guardian Name: _____ Email _____

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
- Behavioural 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: _____