ALIYAH
Medical History Form

Camper's Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship: _____ Phone Number _____

Second Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship: _____ Phone Number _____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: _____ Relationship: _____ Phone Number _____

Health-Care Providers:

Name of Camper's primary doctor(s): _____ Phone: _____

Name of dentist(s): _____ Phone: _____

Name of orthodontist(s): _____ Phone: _____

May the camp contact your child's health care providers? _____

Allergies:

□ No known allergies

Allergic to:

□ Medication: _____

□ Food: _____

□ Insect: _____

□ Latex: _____

□ Others: _____

□ EpiPen for: _____

Provide instructions:

_____

Physical Health History:

Check all that apply.

□ Asthma- **Provide action plan from your physician**
□ Diarrhea, Constipation
□ Back problems
□ Bed Wetting
□ Bleeding, Clotting
□ Chest Pains, Dizzy, Passing out
□ Diabetes- **provide plan & prescription from your physician**
□ Head Injury
□ Heart Murmur
□ High Blood Pressure
□ Immunodeficiency
□ Joint Problems (ankles, knees)
□ Mono, in the last 12
□ Seizures, Convulsions
□ Shortness of Breath, Wheezing
□ Skin Problems
□ Sleep Walking
□ Thyroid Condition

Mental, Emotional, and Social Health: Has the child been diagnosed with any of the following:

□ ADD/ADHD □ Depression □ Eating Disorder □ Learning/Processing
□ Obsessive-compulsive □ Panic, Anxiety □ Substance/Abuse □ Others _____

Has the camper had a significant life event that continues to affect his/her life? (death, divorce, abuse, adoption…)

_____

If the camper has seen a health professional in the past 12 months, please email the camp so the camp can contact you in regard to services.

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the health care providers selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the health care provider to hospitalize, secure proper treatment for, and order injection anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to camper: _____

CONSENT TO TREAT MINORS & INSURANCE INFORMATION

Name: _____ Date of Birth: _____

Primary Insurance Card Front of Card Please confirm that all data is legible	Primary Insurance Card Back of Card Please confirm that all data is legible

Insurance Company: _____ ID #: _____

MENINGOCOCCAL VACCINATION:

State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper or minor staff member who attends camp for seven (7) or more nights. CHECK ONE BOX BELOW.

☐ My Child had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
Date received: _____
[Note: The vaccine protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

☐ I have read or have had explained to me the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

☐ I give permission for my son/daughter to carry and self-apply sunscreen and insect repellant

☐ My son/daughter is unable to apply sunscreen/insect repellant by him/herself. I give permission for the camp staff to assist in the application

IMPORTANT - THIS FORM MUST BE COMPLETED IN ORDER FOR YOUR CHILD TO ATTEND CAMP

I the undersigned, Parent/guardian of the above noted minor, do herby authorize the administration of Mesivta Aliyah as my agent to consent to any diagnostic procedure or medical care which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician and/or surgeon at a hospital or doctor's office. I give permission to the physician selected by the camp to order x-rays, routine tests, and I give permission to the physician selected by Mesivta Aliyah administration to hospitalize, secure proper treatment for, order injections, order anesthesia, or order surgery for my child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to reproduce this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. This authorization shall be in effect until the end of the Summer Camp Season 2024 or until it is evoked in writing and such revocation is delivered to the Mesivta Aliyah office via certified mail.

_____	_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Print Name	Date	Phone Number

PHYSCIAN'S EXAMINATION FORM

Name: _____

Birth Date: _____

TO BE COMPLETED BY PATIENT'S PHYSICAIN

IMMUNIZATION HISTORY:

*IMMUNIZATIONS MUST BE CURRENT. Immunization forms from state governments are acceptable for immunization history only.

		Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Month/Year
Diphtheria, tetanus, pertussis*	(DTap) or (TdaP)						
Tetanus booster*	(dT) or (TdaP)						
Mumps, measles, rubella*	(MMR)						
Polio*	(IPV)						
Haemophilus influenza type B	(HIB)						
Pneumococcal	(PCV)						
Hepatitis B							
Hepatitis A							
Varicella (Chicken Pox)							
Meningococcal meningitis	(MCV4)						
Tuberculosis (TB) test:	Date: _____	□ Negative □ Positive					

PHYSICAL EXAM:

Examination Date: _____

HT: _____ WT: _____ BP: _____

Head: _____ Eyes/Ears/Nose/Throat: _____

Cardiovascular: _____ Lung: _____ ABD: _____

Extremities: _____ GU: _____ Neuro: _____

Patient has the following allergies: _____

Patient has the following medical condition: _____

In my opinion, patient can participate in all camp activities. YES/NO If NO, please specify: _____

Allergies: _____ _____

I authorize standard over the counter medications to be administered as indicated on this form.

Physicians Signature: **License No.:** **Date:**

NON-PRESCRIPTION MEDICATIONS:

THE FOLLOWING MEDICATIONS, OR OTHERS IN THEIR CLASS, ARE ACCEPTABLE FOR ADMINISTRATION EXCEPT AS NOTED BELOW:

- □ Acetaminophen (Tylenol)
- □ Aleve
- □ Aloe
- □ Anti-fungal cream
- □ Antibiotic Cream
- □ Antibiotic Ointment
- □ Antihistamine/allergy medicine
- □ Bismuth Subsalicylate
- □ Calamine lotion
- □ Claritin (Loratadine)
- □ Dextromethorphan
- □ Diphenhydramine antihistamine (Benadryl)
- □ Dramamine
- □ Generic cough drops
- □ Guaifenesin
- □ Hydrocortisone 1%
- □ Ibuprofen
- □ Laxatives for constipation
- □ Lice shampoo or cream
- □ Mylanta/Maalox
- □ Simethicone (anti gas)
- □ Sore throat spray
- □ Sudafed (Pseudoephedrine decongestant)
- □ Sudafed PE (phenylephrine decongestant)
- □ Tums (calcium carbonate)
- □ Visine
- □ Other: _____

PRESCRIPTION MEDICATIONS:

- □ Patient will not take any daily medications while attending camp
- □ Patient will take the following daily medication(s) while at camp

Medication/Dose/When to be taken

Medications

Is your child currently taking any medications?

_____

Please list medications and reasons:

_____

Prescribing Doctor:

_____

Prescribing Doctor phone number:

_____

Please include a prescription from the doctor.