Habonim Dror Camp Gilboa
Camp Health Examination Form

22622 Vanowen St. West Hills, CA 91307 (818)464-3224 Fax (818)464-3299

(This page to be filled in by parent & checked with physician at time of examination.)

Name____Birth Date__________ Sex______Age__________
Last First Initial

Parent or Guardian____________________________(H)Phone__________(W) Phone__________

Home Address____
Street & Number City State Zip Code

Second Parent/Guardian________________________(H)Phone__________(W)Phone__________

Home Address____
Street & Number City State Zip Code

If not available in an emergency, notify:

Name______________________________________(H)Phone__________(W)Phone__________

HEALTH HISTORY
Check. Give approximate dates.

_____Frequent Ear Infections
_____ Heart Defect/ Disease
_____Convulsions
Bleeding/Clotting
_____Chicken Pox
_____Measles
_____German Measles
_____Mumps

Allergies *(dates not needed)*

_____ Hay Fever
_____Ivy Poisoning, etc.
_____Insect Stings
_____Penicillin
_____Other Drugs
_____Asthma
_____Other (Specify)

Operations or serious injuries *(dates)*________________________
____
____

Chronic or recurring illness or medical condition______________
____
____

Current Medications *(send with instructions)*________________
____

Other Diseases____
____

Name of dentist/orthodontist_____________________________
____________________________ Phone:_______________

Name of family physician________________________________
____________________________Phone:_______________

Do you carry family medical/hospital insurance?_____________
____

If so, indicate: Carrier ____________Policy #:______________
____

Suggestions on health related information for Camp personnel:____
____

For Girls: Has she menstruated? ________________________
If not, has she been told about it?________________________
If so, is her menstrual history normal? ___________________

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp corporation to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above. Every effort will be made by the camp administration to immediately contact parents in the event of an emergency.
Unless otherwise specified, Habonim Dror may administre over the counter drugs to your child if needed.

Signature of parent/guardian or adult camper/staffer:____________________________**Date:**________

I also understand and agree to abide with the restrictions place on my camp activities.

Signature of camper:____**Date:** ________

Please place any medications in a sealed envelope--label both medications and envelope with child's name—and hand it to the counselor at the bus.

Name of camper___________________________________

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THIS PAGE TO BE FILLED OUT BY A LICENSED PHYSICIAN

IMMUNIZATION HISTORY

Required immunizations must be determined locally. This is a record of dates and basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diptheria Pertussis (Whooping Cough) Tetanus	1 2 3	1 2
Tetanus Diptheria		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measeles (hard, red, Rubeola)		
Mumps		
Rubella (German Measles, 3-day)		
Other		
Tuberculin test given		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

Height.______________Weight.______________Blood Pressure________

Has child been under a physicians care within the last year?_______________________________

Has child been on any medications within the last year?___________________________________

Current Treatment (include current medications)____

Explanation of any reported loss of consciousness, convulsion, or concussion___________________________________

Does applicant have Epilepsy?_______Diabetes?____________Asthma?_____________

RECOMMENDATIONS & RESTRICTIONS WHILE IN CAMP.

Special Diet____

Special Medicine (name/dosage)____Is parent sending it?__________

Any allergies (food, drugs, plants, insects, etc.)____

Activities to be encouraged or limited____

Other____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that she/he is physically able to engage in camp activities, except as noted above.

Signature: ____Date:________________________

Examining Licensed Physician

Address:____Phone:_______________________

Street & Number *City* *State* *Zip*