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GAN IZZY DAY CAMP
PERSONAL HEALTH AND MEDICAL RECORD

Camper / Staff Member Name:		Date of Birth	
Street Address:		Age:	Sex Male ☐ Female ☐
City, State, Zip Code:			Phone:
Fathers work Phone:	Mothers work Phone:		Cell Phone:

IN CASE OF EMERGENCY, NOTIFY:

1	Name:	Relationship:
	Street Address:	Home Phone:
	City, State, Zip Code:	Other Phone:
2	Name:	Relationship:
	Street Address:	Home Phone:
	City, State, Zip Code:	Other Phone:

DISEASE OR PAST/PRESENT HISTORY OF:

YES	NO		YEAR	DETAILS
☐	☐	Serious Illness		
☐	☐	Serious Injury		
☐	☐	Deformity		
☐	☐	Surgery		
☐	☐	Skin/Glands		
☐	☐	Ears		
☐	☐	Eyes		
☐	☐	Nose/Sinus		
☐	☐	Teeth		
☐	☐	Throat/Tonsils		
☐	☐	Dentures		
☐	☐	Bride		
☐	☐	Chest/Lungs		
☐	☐	Heart		
☐	☐	Murmur		
☐	☐	Rheumatic Fever		
☐	☐	Stomach/Bowels		
☐	☐	Appendicitis		
☐	☐	Kidneys/Bladder		
☐	☐	Infection		
☐	☐	Bed Wetting		
☐	☐	Menstrual Problems		
☐	☐	Hernia Rupture		
☐	☐	Back/Limbs/Joints		
☐	☐	Sleepwalking		
☐	☐	Behavioral Condition		
☐	☐	Other (Specify)		

IMMUNIZATION RECORD

This form may be filled out by parent or guardian, provided all immunization are up to date.

Vaccine Type	Disease Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Polio: Indicate oral or Salk in Corner box. Oral: if monovalent indicate 1,2,3 in corner box. Salk: acceptable if given after 12/31/87						
Measles (Live)						
Rubella						
Mumps						
Diphtheria						
Tetanus						
Pertussis Other						
(Specify)						

Personal health and medical record continued

MEDICAL HISTORY

Most recent physical examination (Date)	Do you have any current health problem? ☐ Yes (explain below) ☐ No
Are you now under medical care, or taking any medications? ☐ Yes (explain below) ☐ No	Has there been any surgery, illness, allergy, or change in health status since last complete physical examination ☐ Yes (explain below) ☐ No
Explanation:	

AUTHORIZATION

To the best of my knowledge, history is correct and complete. I know of no reason to restrict applicant's activity and give my permission for participation in all activities except as specifically noted herein. In the event that I can't be reached in an emergency, I hereby give permission for the physician selected by the camp director to transport, hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. I authorize the officials of the camp to act on my behalf while my child is in their care including the power to authorize Emergency treatment.

I, and on behalf of my child, release and agree not to sue Chabad of Delaware (including its employees) for any damage, claim or injury that my child may sustain, arising from or relating to any activity or Camp experience.

Date	Signature of Parent/Guardian

FOR CAMP USE ONLY

Review by Adult Leader	Date