Camp Moshava of Wild Rose, WI

Under the auspices of Religious Zionists of Chicago and its youth affiliate, Bnei Akiva of Chicago

Please return completed form by May 1st to:
Camp Moshava of Wild Rose, WI
3740 W Dempster St.
Skokie, IL 60076
Fax (847) 750-0222

HEALTH EXAMINATION FORM

For campers and staff under age of 18, health form must be filled out by parent or guardian.

PLEASE CIRCLE PROGRAM:

Matchilim 4 Wk 6 Wk MIT
Machal Sayeret Tzevet

PARTICIPANT INFORMATION

Name ____ Gender _____
Last First

Address ______________________________ City ______________ State ______ Zip __________ DOB _____/_____/_____

PARENT/GUARDIAN INFORMATION

	MOTHER/GUARDIAN	FATHER/GUARDIAN
Name		
Home Phone		
Work Phone		
Mobile Phone/Pager		
Fax		
Email		

Which parent/guardian should be called first in case of emergency? ____________________________________

EMERGENCY CONTACTS (other than parents)

Contact #1 ____ Relationship________________________________

Daytime Phone ______________________ Eve. Phone _________________________ Mobile ____________________

Contact #2 ____ Relationship________________________________

Daytime Phone ______________________ Eve. Phone _________________________ Mobile ____________________

INSURANCE INFORMATION

Health Insurance Carrier ________________________________ Subscriber Name ______________________________

Policy/Group # ______________________________________ Subscriber SS # ______________________________

Insurance Co. Address ____

Insurance Co. Phone # ____

Please Note: In case of accident or illness, Camp Moshava's medical staff will provide treatment at no additional charge to the family. When it is deemed necessary for the camper or staff member to receive further evaluation and/or treatment, the individual will be taken to a hospital, clinic, or specialist's office. Your insurance company will be billed directly for these visits, and you are responsible for the co-payment and/or balance due after the insurance company has remitted payment. You will also be billed for any prescription medications that the camp purchases for your child.

PARENT/GUARDIAN CONSENT

I give permission to the medical staff selected by the camp to provide routine health care and to administer over-the-counter drugs to my child as needed. I give permission to the camp physician to prescribe medications to my child as needed. In case of surgical or medical emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child. Camp Moshava will make every effort to immediately contact parents in the event of an emergency.

I certify that all information provided on both pages of this health examination form is true and correct to the best of my knowledge.

In order to fill prescriptions, a copy of both sides of your insurance card must be attached to this form.

____
Signature of Parent or Guardian **Date**

HEALTH HISTORY

Does your child have, or has your child ever had:

	Yes	No	Comment
Chicken Pox	☐	☐	___
TB/B Contact	☐	☐	___
Birth Defects	☐	☐	___
Blood Disorders	☐	☐	___
Hemophilia ___ Sickle Cell ___ Other ___			
Diabetes	☐	☐	___
Seizures	☐	☐	___
High Blood Pressure	☐	☐	___
Ear/Hearing Probs.	☐	☐	___
Ear Infections	☐	☐	___
Eye/Vision Problems	☐	☐	___
Speech Problems	☐	☐	___
Asthma	☐	☐	___
Serious Injuries	☐	☐	___
Bone/Joint Problems	☐	☐	___
Back Injury?	☐	☐	___
Developmental Delay	☐	☐	___
Surgery	☐	☐	___
When ___ What for ___			
When ___ What for ___			
Hospitalization	☐	☐	___
When ___ What for ___			
When ___ What for ___			

	Yes	No	Comment
Fainting or dizziness while exercising?	☐	☐	___
Chest pain during or after exercise?	☐	☐	___
Heart Problems?	☐	☐	___
A Heart Murmur?	☐	☐	___
Chronic or recurring illness or condition?	☐	☐	___
Frequent headaches?	☐	☐	___
Any loss of consciousness, concussion, or head injury?	☐	☐	___
An orthodontic appliance being brought to camp?	☐	☐	___
Skin problems (e.g., itching, rash, acne)?	☐	☐	___
Any recent injury, illness, or infectious disease?	☐	☐	___
Mononucleosis in the past 12 months?	☐	☐	___
Problems with diarrhea/ constipation?	☐	☐	___
If female, an abnormal menstrual history?	☐	☐	___

SPECIAL INSTRUCTIONS

Please describe any special medical needs, instructions, or restrictions. Attach a separate page, if necessary.

MEDICATIONS

Name of medication	Dosage	Frequency	Reason for taking
Please list over-the-counter medications used at home:			
Please list any over-the-counter medications your child may NOT receive:			

ALLERGIES

Please list:

___

___

___

Comments:

DID YOU REMEMBER TO:

• Sign the bottom of the front side of this form? • List allergies & medications? • Include a copy of both sides of insurance card?

TO BE COMPLETED BY HEALTH CARE PROVIDER

Physical examination: **Normal** _____ **Abnormal** _____ **Height** _____ **Weight** _____ **BP** _____

Abnormal findings ___

IMMUNIZATIONS

Please note the month/day/year for every dose administered.

Dose	Mo/d/yr	Mo/d/yr	Mo/d/yr	Mo/d/yr	Mo/d/yr
Diphtheria, Pertusis & Tetanus (DTP or DtaP)					
Diphtheria and Tetanus (DT or Td)					
Polio (TOPV or IPV) Specify if IPV					
Haemophilus Influenza type b (Hlb)					
Comb. Measles/Mumps Rubella (MMR)					
Measles (Rubella)					
Rubella (3-day or German Measles)					
Mumps					
Hepatitis B (HB)					
Other (e.g. Varicella)					
Tuberculosis Test – **REQUIRED for AVODAH**					

Alternative Proof of Immunization

Clinical diagnosis is acceptable if verified by physician

1. Measles ___ M/d/yr Mumps ___ M/d/yr

2. Laboratory confirmation of any disease is acceptable

Disease ___

Lab Results ___

Date ___

Disease ___

Lab Results ___

Date ___

SIGNATURE OF LICENSED MEDICAL PERSONNEL: ___ Date ___

Physician's name (please print) ___ Hospital Affiliation ___

Address ___ Office phone # ___