



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 West Dempster St.
Skokie, IL 60076
Fax (847) 674-9736

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 1st 2nd Av. 1/Machal
Mach Hach/Av. 2 MIT 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 sides 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

Camper Name _____ Last _____ First _____

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

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

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

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.						Alternative Proof of Immunization	
Dose	Mo/d/yr	Mo/d/yr	Mo/d/yr	Mo/d/yr	Mo/d/yr	Clinical diagnosis is acceptable if verified by physician	
Diphtheria, Pertusis & Tetanus (DTP or DtaP)						1. Measles _____ Mumps _____	
Diphtheria and Tetanus (DT or Td)						M/d/yr M/d/yr	
Polio (TOPV or IPV) Specify if IPV						2. Laboratory confirmation of any disease is acceptable	
Haemophilus Influenza type b (Hib)						Disease _____	
Comb. Measles/Mumps Rubella (MMR)						Lab Results _____	
Measles (Rubella)						Date _____	
Rubella (3-day or German Measles)						Disease _____	
Mumps						Lab Results _____	
Hepatitis B (HB)						Date _____	
Other (e.g. Varicella)							
Tuberculosis Test – REQUIRED for AVODAH							

SIGNATURE OF LICENSED MEDICAL PERSONNEL: _____ Date _____

Physician's name (please print) _____ Hospital Affiliation _____
 Address _____ Office phone # _____