# KOL NESHAMA CONFIDENTIAL MEDICAL FORM

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|---|---|
| CAMPER'S NAME<br>_____<br>CAMPER'S LEGAL NAME<br>_____<br>HOME ADDRESS _____<br>_____<br>DATE OF BIRTH _____<br><br>___ If you would like the Camp Director to call you before camp regarding confidential medical information in reference to your child, please check here. This information will be kept strictly confidential. | HOME PHONE #_____<br>FATHER'S WORK #_____<br>FATHER'S CELL #_____<br>MOTHER'S WORK #_____<br>MOTHER'S CELL #_____<br><br>IF PARENTS CAN'T BE REACHED IN CASE OF EMERGENCY CALL:<br>NAME _____<br>PHONE _____<br>NAME _____<br>PHONE _____ |

Paste copy of insurance card below: front and back

Please list any special circumstances or conditions that our staff should be aware of to assist us in the care of your child (e.g. frequent colds, headaches, stomach aches, diarrhea/constipation, vomiting, bed wetting, sensitivity to insect bites, nightmares, anxiety reactions, etc.) and what you recommend as treatment:

_____

_____

_____

**IMPORTANT:** The camp office MUST be notified if your child is exposed to any communicable disease during the three weeks prior to camp attendance.

**DEPARTMENT OF HEALTH REGULATIONS REQUIRES THE FOLLOWING AUTHORIZATIONS IF YOUR CHILD ATTENDS A SLEEP-AWAY CAMP:**

## PARENT'S AUTHORIZATION

The health history record below (page 3) is correct as far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by myself and the examining physician.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child _____, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

Parent(s) Signature _____
Date_____

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## AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM PARENTS

I/We, the undersigned, parent(s) of _____, a minor, do hereby authorize Kol Neshama as our agent to consent to any diagnostic procedure of medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician and surgeon at a hospital in Israel when such diagnosis or treatment is rendered at said hospital.

It is understood that this authorization is given in advance of any specific need of treatment but is given to provide authority on the part of our aforesaid agent to give specific consent to any and all such diagnoses, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable. This authorization shall remain effective until August 13, 2017, unless sooner revoked in writing delivered to said agent.

Parent(s) Signature _____
Date_____
Phone Number of Parents_____

## ** TO BE COMPLETED BY EXAMINING PHYSICIAN **

### IMMUNIZATION HISTORY

Required immunization must be determined locally.

| IMMUNIZATION | DATE BASIC SERIES COMPLETED | MOST RECENT BOOSTER |
|---|---|---|
| DPT or DT | | |
| TINE TEST | | |
| TETANUS | | |
| ORAL POLIO | | |
| MMR | | |
| MEASLES | | |
| MUMPS | | |
| RUBELLA | | |

### ALLERGIES

| | Comments |
|---|---|
| PENICILLIN | |
| ASPIRIN | |
| SULFA | |
| OTHER DRUGS | |
| FOODS | |

### SPECIAL RESTRICTIONS

| | |
|---|---|
| DIET | |
| STRENUOUS ACTIVITY | |
| OTHER | |

List dates and description of operations, serious injuries, fractures:

_____

_____

### MEDICAL HISTORY

| | Indicate Date of Illness |
|---|---|
| CHICKEN POX | |
| MEASLES | |
| GERMAN MEASLES | |
| MUMPS | |
| HEPATITIS | |
| PNEUMONIA | |

| | Indicate if being treated for the following: |
|---|---|
| DIABETES | |
| CONVULSIONS | |
| HAY FEVER | |
| ASTHMA | |
| FREQUENT STREP THROAT | |
| FREQUENT EAR INFECTIONS | |

### CURRENT MEDICATIONS

| NAME OF MEDICATION | DOSAGE | BRINGING TO CAMP YES / NO |
|---|---|---|
| | | |
| | | |
| | | |

Chronic or recurrent illness and suggested treatment:

_____

_____

_____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper listed above is physically able to engage in all camp activities, except as noted above.

DATE: _____ PHYSICIAN'S SIGNATURE: _____

OFFICE/CONTACT NUMBER & ADDRESS: _____

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