CAMP RAMAH IN CALIFORNIA, INC.
15600 Mulholland Drive #252, Los Angeles, CA 90077
(888) camp-ramah or (310) 476-8571
info@ramah.org

2008 MEDICAL FORM

This form must be returned directly to the above address by April 1st

NAME________________________
Last, First initial
BUNK________________________
EDAH________________________
For office use only

❒ 1st Session ❒ 2nd Session ❒ Gesher A B C D E ❒ Staff (under 18) ❒ Gan Child

CAMPER INFORMATION

(MUST BE COMPLETED BY A PARENT/GUARDIAN. PLEASE TYPE OR PRINT CLEARLY WITH A PEN.)

Camper Name: (last, first)	Sex: M F	Home Phone #s: ( ) ( )
Address:		Camper's Social Security #
Date of Birth: Mo/Day/Yr	Grade in School: (as of Fall after camp)	Age (Yrs/Mos): (as of Fall after camp)

PARENT CONTACT INFORMATION

Child lives primarily with: ❒ Both Parents ❒ Mother ❒ Father ❒ Other	Name of Legal Guardian:
Father Name: (last, first) Mr. Dr. Rabbi	Mother Name: (last, first) Mrs. Ms. Dr. Rabbi
Father's Bus. Address:	Mother's Bus. Address:
Bus. Phone: ( ) Fax: ( ) Pager: ( ) Cell: ( )	Bus. Phone: ( ) Fax: ( ) Pager: ( ) Cell: ( )
Father's Occupation:	Mother's Occupation:

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Camper:
Bus. Phone: ( ) Fax: ( ) Pager: ( ) Cell: ( )	Address:

GRANDPARENT CONTACT INFORMATION

Name:	Name:
Phone: ( ) Address:	Phone: ( ) Address:

PARENT'S AGREEMENT, MEDICAL AUTHORIZATION, AND HEALTH INSURANCE INFORMATION

Please read carefully and sign below

I hereby give permission to the Camp Director or his representative to authorize the administration of health care service to my child by a physician or other professional health care provider (hospital, paramedic, nurse, etc.). I also give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child. It is understood that the camp cannot assume responsibility for the payment, adequacy or quality of service rendered by the physician or other health care providers selected in such an emergency. I also give my permission to the physician or camp personnel selected by the Director to advise or treat my child for any illnesses or medical condition while he or she is at camp. **This completed form may be photocopied for trips out of camp.*

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health plan, or other health care provider (My Child's Providers) that has provided treatment or services to my child or on my child's behalf to disclose my child's entire medical record and any other protected health information concerning me to Camp Ramah in California and its agents, employees, and representatives. By signing below, I terminate any agreements I have made with My Child's Providers to restrict protected health information and I instruct My Child's Providers to release and disclose my child's entire medical record without restriction.

Liability limits of Camp Ramah's insurance: In case of illness or accident, all claims must be filed initially with your individual insurance carrier. The camp's insurance will cover deductibles and other amounts not covered by your private insurance carrier up to a limit of $1,000. In the absence of insurance coverage, parent/guardian accepts responsibility for medical costs. Parent accepts all responsibility for costs of medications prescribed, dental and orthodontic treatments. I authorize the camp to deal directly with my health insurance which is:

Name of Insurance Co.:________________________________ Policy #________________

Address of Insurance Co.: ________________________________ Phone #________________

Employer's Name: ________________________ Subscriber's Name________________________

*I have enclosed a copy of both sides of my medical insurance and prescription card plans.

Signature: ________________________________ Date: ________________________

HEALTH HISTORY   Camper's Name___________________________

The following information must be filled in by the parent/guardian, or staff member. The intent of this information is to provide camp health care personnel with the background to administer appropriate care. **Keep a copy of the completed form for your records.** Any changes to this form must be provided to camp health care personnel upon participant's arrival to camp. Please provide complete information so that the camp can be aware of your child's needs (use additional pages if necessary).

ALLERGIES (to include medication, food and other miscellaneous allergies)

List All Known	Describe reaction & management of the reaction

MEDICATIONS BEING TAKEN

Please list all prescription medications routinely taken. Drug holidays are not encouraged at camp. List only prescription medications. Non-prescriptions or over-the-counter medications will be administered at the discretion of the camp physician only. **Send ONLY ENOUGH medications for the entire time at camp – no more. Medications cannot be returned when the campers return home** (except metered dose inhalers and injections). All medications must be submitted in the properly labeled original container, which identifies the prescribing physician, the name of the medication, the dose and the frequency of administration. Any unlabeled medications sent to the camp will be discarded. The cost of replacement prescriptions, if necessary, will be charged back to the parents.

❒ **This person takes NO medications on a routine basis.**

❒ This person takes medications as follows:

Medication	Dosage	Specific Times Taken Daily	Reason For Taking

Attach additional pages for more medication.
Identify any medications taken during the school year that participant does not or may not take during the summer:

____

MEDICATIONS WILL ONLY BE DISPENSED AS LISTED ABOVE BY YOU AND AS CONFIRMED BY YOUR PHYSICIAN.

RESTRICTIONS

The following restrictions apply to this individual:
Dietary:____

____

Other: Please explain any activity-related restrictions (e.g. what cannot be done, what adaptations or limitations are necessary)____

____

To the best of my knowledge, my child ❒ is ❒ is not fully immunized.
*All children coming to camp MUST be fully immunized or cannot attend camp.

Which of the following has the participant had?

	Dates
❒ Measles	__________________
❒ Chicken Pox	__________________
❒ German Measles	__________________
❒ Mumps	__________________
❒ Hepatitis	__________________

Please give date for last immunization for:

Vaccine	Dates
DTP or Td or DtaP	______________________
Polio	______________________
Chicken Pox	______________________
MMR	______________________
Haemophilus influenza B	______________________
Hepatitis B	______________________

Last TB Mantoux Test Date:___________________ Result: ____

GENERAL QUESTIONS (Explain "yes" answers below.) Camper's Name__________________________

Has/does the participant:

#	Question	YES	NO
1.	Had any recent injury, illness or infectious disease?	❒	❒
2.	Have a chronic or recurring illness/condition?	❒	❒
3.	Ever been hospitalized?	❒	❒
4.	Ever had surgery?	❒	❒
5.	Have frequent headaches	❒	❒
6.	Ever had a head injury?	❒	❒
7.	Ever been knocked unconscious?	❒	❒
8.	Wear glasses, contacts or protective eyewear?	❒	❒
9.	Ever had frequent ear infections?	❒	❒
10.	Ever passed out during/after exercise?	❒	❒
11.	Ever been dizzy during/after exercise?	❒	❒
12.	Ever had seizures?	❒	❒
13.	Ever had chest pain during/after exercise?	❒	❒
14.	Ever had high blood pressure?	❒	❒
15.	Ever been diagnosed with a heart murmur?	❒	❒
16.	Ever had back problems?	❒	❒
17.	Ever had problems with joints (e.g. knees, ankles)?	❒	❒
18.	Have an orthodontics appliance being brought to camp?	❒	❒
19.	Have any skin problems (e.g. itching, rash, acne)?	❒	❒
20.	Have diabetes?	❒	❒
21.	Have asthma?	❒	❒
22.	Had mononucleosis?	❒	❒
23.	Had problems with diarrhea/constipation?	❒	❒
24.	Have problems with sleepwalking?	❒	❒
25.	If female, have an abnormal menstrual history?	❒	❒
26.	Have a history of bedwetting?	❒	❒
27.	Have an eating disorder?	❒	❒
28.	Ever had emotional difficulties for which professional help was sought?	❒	❒
29.	Ever used tobacco, have an addiction or substance abuse history?	❒	❒

Please explain all "yes" answers to above questions (noting the number of the question.)

____

____

____

____

____

Has participant ever seen a psychiatrist or other mental health professional? ❒ Yes ❒ No If yes, when and for what reason?

____

____

MENTAL HEALTH PROFESSIONAL CONTACT INFORMATION

Name:	Phone ( )
Address:	

Family medical/social concerns we should be aware of (i.e. recent divorce, serious illness, etc.):

____

____

____

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.

____

____

MEDICAL CONTACT INFORMATION

Physician Name:	Phone ( )
Address:	
Orthodontist Name:	Phone ( )
Address:	

Parent/Guardian Authorization: This health history is correct and complete as far as I know and the person herein described is fully immunized and has permission to engage in all activities except as noted.

Signed: ______________________________ Print Name: ______________________________ Date: ______________

Camper's Name____________________________

TO BE COMPLETED BY PHYSICIAN

I have examined the above camp participant. Date of last examination: ______________________________

BP ________________________________ Weight: _________________________ Height:___________________

In my opinion, the above applicant ❒ is❒ is not able to participate in active camp program, and ❒ is❒ is not currently appropriately immunized for his/her age.

The applicant is under the care of a physician for the following conditions:
____

____

Current treatment at the time of this report includes:
____

____

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Treatment to be continued at camp:
____

____

Medications to be distributed at camp:

Name	Dosage	Frequency	Reason

Any medically prescribed meal plan or dietary restrictions:
____

____

Known allergies:
____

____

Description of any limitation or restriction on camp activities:
____

____

Additional information for health care staff at camp:
____

____

Signature of Licensed Medical Personnel:		Date:
Print Name		Title:
Phone ( )	Fax ( )	Address:

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Screening Record – Screened by:____ Date Screened: ________________________

Meds Received: ____

Updates/additions to health history noted ❒ Yes ❒ No ❒ None required

Current health needs identified: ____

Observational notes: ____

____