

GAN ISRAEL

PERSONAL HEALTH AND MEDICAL RECORD

Camper Name	Date of Birth
Street Address	Age <input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, Zip Code	

IN CASE OF EMERGENCY, NOTIFY (Please list someone other than a parent.)

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		Yes	No	Year	Details
<input type="checkbox"/>	<input type="checkbox"/>	_____	Serious Illness		<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart
<input type="checkbox"/>	<input type="checkbox"/>	_____	Serious Injury		<input type="checkbox"/>	<input type="checkbox"/>	_____	Murmur
<input type="checkbox"/>	<input type="checkbox"/>	_____	Deformity		<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	_____	Surgery		<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach/Bowels
<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin/Glands		<input type="checkbox"/>	<input type="checkbox"/>	_____	Appendicitis
<input type="checkbox"/>	<input type="checkbox"/>	_____	Ears		<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidneys/Bladder
<input type="checkbox"/>	<input type="checkbox"/>	_____	Eyes		<input type="checkbox"/>	<input type="checkbox"/>	_____	Infection
<input type="checkbox"/>	<input type="checkbox"/>	_____	Nose/Sinus		<input type="checkbox"/>	<input type="checkbox"/>	_____	Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	_____	Teeth		<input type="checkbox"/>	<input type="checkbox"/>	_____	Menstrual Problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Throat/Tonsils		<input type="checkbox"/>	<input type="checkbox"/>	_____	Hernia Rupture
<input type="checkbox"/>	<input type="checkbox"/>	_____	Dentures		<input type="checkbox"/>	<input type="checkbox"/>	_____	Back/Limbs/Joints
<input type="checkbox"/>	<input type="checkbox"/>	_____	SARS		<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleepwalking
<input type="checkbox"/>	<input type="checkbox"/>	_____	Chest/Lung		<input type="checkbox"/>	<input type="checkbox"/>	_____	Behavioral Condition
<input type="checkbox"/>	<input type="checkbox"/>	_____	Other, specify: _____				_____	

IMMUNIZATION RECORD (Required by Law)

Vaccine Type	Disease Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd 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						
Other (specify) DPT/HB						

In the case of an emergency and medical treatment is required (during camp or thereafter related to camp), I hereby declare that my child has Medical insurance to cover all the cost or I will be fully responsible for any medical cost incurred and not hold the camp at all responsible.

Print Name _____

Signature _____

Date_____