



Mishkan Israel Day Camp

Office: 77 Mt. Pleasant Dr. Trumbull, CT 06611
Phones: (203)428-4130, (203)268-0740, (914)595-4661
www.Mishkanisrael.com · Mishkanday@aol.com

Youth Camp Health Examination Record

To be completed by parent or guardian

Name _____ Sex _____ Age _____ Birth Date _____

Address _____ Phone _____

Health History

Chickenpox Measles German Measles Mumps Whooping Cough

Other please specify _____

Additional Details _____

Allergies

Hay Fever Insect sting (specify) Asthma Poison Ivy, Oak, etc.

Drug(s) Specify if checked: _____

Foods Specify if checked: _____

Chronic/Recurring Illness

Earaches Throat problems Sinus Infections Heart Stomach Epilepsy

Rheumatic Fever Diabetes Menstrual Problems Medications being taken

(Name & Specify for what illness if checked) _____

Operations, injuries, special restrictions if any _____

Details _____

Immunizations

Diphtheria Date: _____ Tetanus Date: _____

Pertussis Date: _____ Polio Date: _____

Measles Date: _____ Mumps Date: _____

Rubella Date: _____ Other Specify _____ Date: _____



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Parent or Guardian Authorization (Required for all persons under age 18)

This health history is correct so far as I know and the person named above (on page 1) has permission to participate in all camp activities except as noted by me or the examining physician. If I cannot be reached in an emergency, God forbid, I hereby give my full permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia for surgery for the person named above, or perform any other medical procedure to remedy the situation.

Signature _____ Date _____

Physical Examination to be Completed by a Licensed Physician

Good (1) – Satisfactory (2) Not Satisfactory (3) Not examined)

Height ____ Weight ____ B.P. ____ Skin ____ Nose ____ Eyes ____ Glasses/Contacts ____ Required
____ Condition ____

Ears ____ Hearing Right ____ Hearing Left ____ Throat ____ Teeth ____ Heart ____ Lungs ____ Skeletal
____ Abdomen ____ Genitalia ____

Hernia ____ Extremities ____ Tests Urinalysis Glucose ____ Albumin ____ Tuberculin Testing (Type)
____ If Indicated Blood Count ____

Restrictions/Limitations (Including Diet) _____ Medications _____

Recommendations _____

The above name person is in satisfactory condition and may engage in all camp activities except as noted date _____

Examining Physician _____ State Licensed No. _____ License No. _____

Phone _____

Address _____

Hospital (If applicable) _____

Emergency Phone _____

Physician's signature: _____ Date: _____