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 · Mishkanisrael@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: _____