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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: _________________________