



WILSHIRE BOULEVARD
TEMPLE CAMPS
MALIBU, CALIFORNIA

HEALTH EXAMINATION FORM

■ Staff

FORM MUST BE RETURNED BY MAY 1, 2010

Mail to: Wilshire Boulevard Temple Camps
3663 Wilshire Boulevard
Los Angeles, CA 90010-2798
T: (213) 388-2401 F: (213) 388-2595

For office use only
GHC/CHK:

To be completed by Staff Member

Name _____

Street Address _____ Email (required) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Parent/Guardian _____

Street Address _____ Email (required) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____

(other than listed above) Phone _____ Cell Phone _____

INSURANCE INFORMATION

ATTACH A COPY OF FRONT AND BACK OF INSURANCE CARD

Medical Insurance Carrier _____ Phone _____

Subscriber/Membership # _____ Group # _____

Address of Insurance Carrier _____

Subscriber's Name _____ Relationship to Staff _____

The Camp's medical insurance is secondary to family insurance coverage.

Consent for treatment and emergency treatment (of a minor), pursuant to California State Law:

I, (parent/legal guardian of) _____ (staffer's name), attest that this health history is accurate, and that I have (my child has) permission to engage in all Camp activities, except as may be noted on this form. I authorize the Camp Director to consent, in my absence, to all x-ray examination, anesthetics, medical, dental and surgical diagnosis and treatment, and/or hospital care as may be necessary to be rendered to me (to my child). All care provided is to be under the direct supervision of a physician or dentist licensed under the Medical Practices Act of the State of California. I also give my permission to the physician, nurse, or camp personnel selected by the Camp Director to advise or treat me (my child) for any illnesses or medical condition while I am (he/she is) at Camp. I further authorize any physician, nurse, or other health care provider, to communicate with the medical staff and the Camp Director, or his/her designee about my (my child's) medical condition, treatment, and/or prognosis. I further authorize the camp medical staff to discuss any medical conditions with the Director, or his/her designee, when the medical staff, in its sole discretion, believes such communication to be in my (my child's) best interest. I also give permission to the Camps to transport me (my child) to and from Camp and on field trips, in the insured motor vehicles, driven by authorized drivers. This authorization/consent is effective from June 1, 2010 through August 31, 2010.

*Signature of Adult Staff _____ Date _____

or Signature of Parent/Guardian (if staff member is under 18)



HEALTH HISTORY

This form to be completed by Staff Member

- A. Have you been hospitalized overnight? No Yes _____
- B. Have you had any recent injury requiring treatment at Camp? No Yes _____
- C. Had any serious injury or illness? No Yes _____
- D. Have you had any surgery? No Yes _____
- E. Do you have any chronic medical condition? No Yes _____
- F. Are you restricted from any camp activity? No Yes _____
- G. Will you bring an orthopedic device, brace, splint, etc.? No Yes _____
- H. Do you have orthodontia? No Yes _____
Name/Phone of Orthodontist _____
- I. Seizures? No Yes _____
- J. Asthma? No Yes _____
- K. Bleeding Disorder? No Yes _____
- L. Diabetes ? No Yes _____
- M. Heart Condition? No Yes _____
- N. Other No Yes _____

STAFF MEMBER IS ALLERGIC TO THE FOLLOWING:

Describe allergic reaction

Medication _____

Food _____

Insect _____

Other _____

MEDICATION:

All medication, including over-the-counter medication, must be in an original, labeled container. Staff must store all medication in the Health Center and staff members will be solely responsible for dispensing their own medication.

Staff member takes **no medication on a daily basis**

Staff member takes daily medication as follows:

Med #1 _____ Dosage _____ Reason for taking _____

To be taken: At Wake-up Breakfast Lunch Dinner Bed Other _____ Or, As needed only

Med #2 _____ Dosage _____ Reason for taking _____

To be taken: At Wake-up Breakfast Lunch Dinner Bed Other _____ Or, As needed only

Med #3 _____ Dosage _____ Reason for taking _____

To be taken: At Wake-up Breakfast Lunch Dinner Bed Other _____ Or, As needed only

Med #4 _____ Dosage _____ Reason for taking _____

To be taken: At Wake-up Breakfast Lunch Dinner Bed Other _____ Or, As needed only

Med #5 _____ Dosage _____ Reason for taking _____

To be taken: At Wake-up Breakfast Lunch Dinner Bed Other _____ Or, As needed only

Identify any medications taken during the school year that participant may not bring to Camp _____

Medication holidays are not encouraged at camp.



HEALTH HISTORY *continued*

To be completed ENTIRELY by licensed medical personnel or their legal designee only.

Staff Member's Name _____

The most recent physical exam must be within 24 months of the start date of camp (June 2010).

Please fill out completely or attach copy of immunization record to last page of form. The camp DOES NOT refer to past records.

REQUIRED IMMUNIZATIONS AND DATES:

| | #1 | #2 | #3 | #4 | #5 | Booster | |
|---------------------------|------------|---------------------|------------------|--|----|---------|------------------------------|
| Polio | | | | | | | booster within last 10 years |
| DTP/dT | | | | | | | |
| MMR | | | 2nd MMR required | | | | |
| Hepatitis B | | | | | | | |
| Varicella | | or date of disease: | | | | | |
| TB Skin Test (Mantoux) | Date Given | Date Read | Result | No Risk Factors, TB Skin Testing not indicated | | | |
| | | | | | | | |
| Hepatitis A | | | Not required | | | | |

Date of most recent Exam _____ Weight _____ Height _____

Must be within 24 months of the camp start date (June 2010)

In my opinion, this child IS IS NOT able to participate in an active camp program, if not please explain. This child is under my (or another physician's) care for the following conditions and/or takes the following medications:

The above named child had a complete physical exam performed by me. The Health History and Immunization Records have been reviewed. There is no apparent contradiction to full participation in Camp activities and sports, unless described above.

SIGNATURE (required) _____ Date signed _____

Printed Name _____ Phone _____

Address _____

License Number (California Medical Board or Board of Registered Nursing for Nurse Practitioners) _____

FOR CAMP USE ONLY

