



HEALTH EXAMINATION FORM

■ Camper & CIT

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
Session:

To be completed by Parent/Guardian

Camper's Name _____ Grade in Fall 2010: _____

First Contact Parent/Guardian _____

Street Address _____ Email (required) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Second Contact Parent/Guardian _____

Street Address _____ Email (required) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Are parents: Married Divorced Separated Other _____ With whom does camper reside _____

Emergency Contact _____ Relationship _____

(other than parents) Phone _____ Cell Phone _____

I/We will be traveling while my/our camper is at Camp from ___/___/___ to ___/___/___.

The following person has our itinerary _____ 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 Camper _____

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, _____ the legal guardian of _____, a minor, attest that this health history is accurate, and that the child has permission to engage in all Camp activities, except as may be noted on this form. I authorize the Camp Director and/or his/her designee 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 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 further give my permission to the physicians, nurse, or camp personnel selected by the Camp Director to advise or treat my child for any illnesses or medical condition while he/she is at Camp. I authorize any physician, nurse, or other health care provider, to communicate with the medical staff and the Camp Director, or his/her designee including counselors and other staff, about my child's medical condition, treatment, and/or prognosis when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

These authorizations are limited to June 1 through August 31, 2010.

Signature of Legal Guardian _____ Date _____



HEALTH HISTORY

This form to be completed by Parent/Guardian

- A. Has camper been hospitalized overnight? No Yes _____
- B. Has camper had any recent injury requiring treatment at Camp? No Yes _____
- C. Had any serious injury or illness? No Yes _____
- D. Has camper had any surgery? No Yes _____
- E. Does the camper have any chronic medical condition? No Yes _____
- F. Is camper restricted from any camp activity? No Yes _____
- G. Will the camper bring an orthopedic device, brace, splint, etc.? No Yes _____
- H. Does the camper 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 _____

CAMPER IS ALLERGIC TO THE FOLLOWING:

Describe allergic reaction

Medication _____

Food _____

Insect _____

Other _____

MEDICATION:

All medication **given on a daily basis**, including over-the-counter medication, vitamins, nutritional supplements, etc., **MUST** be packaged by **CampMeds Inc.**, **NO EXCEPTIONS**

Camper takes **no medication on a daily basis**

Camper 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 a licensed medical personnel or their legal designee only.

Camper's Name _____ Session _____

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



PERSONAL INFORMATION FROM PARENT TO CAMP STAFF

This form to be completed by Parent/Guardian

The personal information forms will be shared with your camper's counselor.

Please complete and return with medical form

OR detach and return by **May 1, 2010**

to Wilshire Boulevard Temple Camps

3663 Wilshire Boulevard

Los Angeles, CA 90010-2798

T: (213) 388-2401 F: (213) 388-2595

Session Name _____ Date _____

Camper's Name _____ Nickname _____ M/F _____

Camper birth date _____ Name of School _____ Grade in Fall 2010 _____

This sheet is being completed by _____ Relationship _____

Camper lives with: Both parents Father Mother Other (please specify) _____

Please note: The more detailed and candid information you provide us about your child the better able we will be to serve his or her needs. Your child's counselors will review these forms with the Head Counselor and/or Unit Heads.

What are your goals for your child this summer, and how can we help him/her attain these goals? _____

Are there any special circumstances or family issues that may affect your child this summer? (divorce, death, illness, new baby, new marriage, etc.) _____

Are there any personal matters of which we should be aware? (fears, bed-wetting, etc.) _____

Socially, how would you describe your child? (shy, out-going, makes friends easily, etc.) _____

Are there any learning or social issues of which we should be aware? (ADHD, Dyslexia, Asperger's, etc.) _____

Are there any health matters of which we should be aware? (allergies, asthma, etc.) _____

Is your child currently taking any medication? Which one(s)? _____ for _____

Will he/she be taking this medication while at camp? _____

(**If camper takes meds at home, please continue through the summer**)

Has your child expressed any concerns, fears or anxieties about going to camp? _____

What is effective discipline for your camper at home? ("time-outs", discussion, consequences, etc.) _____

What are good rewards for your camper at home? _____

The best way to reach me in case of an emergency or behavioral issue is: _____

Please complete, if applicable: I/We will be traveling from (date) _____ to (date) _____ while my/our camper is at Camp.

(Name of Person) _____ has my/our itinerary. He/she can be reached at: Cell _____ Day/Evening _____

We prefer that this document is completed and returned in its entirety. However, if you require more time for the non-medical portion of this form, please detach here and mail to the address indicated by May 1, 2010



CAMPER INFORMATION AND PERSONAL INTEREST FORM

This form to be completed by the CAMPER

Please complete and return with medical form
OR detach and return by May 1, 2010
to Wilshire Boulevard Temple Camps
3663 Wilshire Boulevard
Los Angeles, CA 90010-2798
T: (213) 388-2401 F: (213) 388-2595

Session Name _____ Date _____

The information on this page is important for your counselors. We can plan a better summer for you if we know what you want and what you have to contribute.

Full Name _____ Nickname _____

Street Address _____ City _____ State _____ Zip _____

School Name _____ Your grade in Fall 2010 _____

Have you ever been away from home before? No Yes If yes, for how long? _____

Have you ever attended Camp before? No Yes If yes, please give year(s) and Camp(s):
Year _____ Camp _____ Year _____ Camp _____

What are your hobbies? _____

Which sports do you enjoy? _____

What musical instrument do you play? _____

What are you favorite foods? _____

What is your favorite way to spend a free afternoon? _____

What are your favorite T.V. shows? _____

What is your favorite musical group or singer? _____

What are your special talents? (everyone has at least 1!) _____

Which camp activity do you enjoy most? _____

Which camp activity do you enjoy least? _____

What are your goals this summer? (make new friends, hike, learn how to swim, etc) _____

Is there anything that you are afraid or worried about at camp? If so, what? _____

What can we do to make this your best summer ever? _____

Is there anything else that you would like us to know about you? _____



We prefer that this document is completed and returned in its entirety. However, if you require more time for the non-medical portion of this form, please detach here and mail to the address indicated by May 1, 2010

