



Camp Gan Israel
C/O Chabad of Orange County
 Rabbi Pesach & Chana Burston, Directors
 1170 Route 17, Suite 1, Chester, NY 10918



Phone: 845-782-2770 ♦ **E-mail:** camp@ChabadOrange.com ♦ **Web:** www.ChabadOrangeCamp.com

B"H.

CAMP GAN ISRAEL Health History and Medical Release

Please have your child's primary care physician complete the following form(s) and return it before camp begins. **NO CHILD WILL BE ALLOWED TO ATTEND CAMP WITHOUT A COMPLETED MEDICAL RELEASE FROM THE CHILD'S PHYSICIAN.**

CHILD'S FULL NAME: _____ **DATE OF BIRTH:** _____

NAME OF PRIMARY CARE PHYSICIAN/PRACTICE: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE #: _____

PAST OR PRESENT CONDITIONS, ALLERGIES, ILLNESS (ES) AND/OR INJURIES OR SURGERY: _____

MEDICATION(S) CURRENTLY BEING TAKEN (NAME, DOSAGE, CONDITION): _____

DOES THE CHILD NEED TO BE GIVEN MEDICATION DURING CAMP? IF YES, PLEASE ADVISE EXACT INSTRUCTIONS ON HOW MEDICATION SHOULD BE GIVEN (NAME OF MEDICATION, AMOUNT, NUMBER OF PILLS, TIMES, SIDE EFFECTS, RESTRICTIONS, ETC.): _____

PLEASE ATTACH A COPY OF IMMUNIZATIONS: DPT, MMR, TB, HIB, TETANUS, HEP B, POLIO (TOPV), CHICKEN POX.

On the basis of past medical exams and the child's history, is there any medical reason why this child should not participate in all camp sports, trips and activities? _____

If yes, please explain: _____

I have examined the above camp applicant within the past year. All information listed above is correct to the best of my knowledge.

Signature of Physician: _____

Name of Physician (please print): _____

Date _____