

CAMP MENORAH

A Day Camp for Boys & Girls Ages 3-16

Located on the scenic shores of Lake Chebacco in Essex

Mailing Address: 3 Bessom Street #158
Marblehead, MA 01945

Summer / Camp Address: 19 Wood Drive
Essex, MA 01929

Office Phone: 781-631-8081

Summer / Camp Phone: 978-768-6941

HEALTH & EXAMINATION FORM – For Campers & Staff

This side to be filled out by parent or adult and checked with physician at time of examination.

Name: _____ Birth Date: _____ Sex: M F Age: _____

Home Address: _____

Home Phone: _____ Spouse (if Staff Member): _____

First Parent / Guardian: _____ Second Parent / Guardian: _____

Work / Day Phone: _____ Work / Day Phone: _____

Cell Phone: _____ Cell Phone: _____

Insurance Company: _____ Policy Number: _____

If not available in an emergency, notify:

1. Name: _____ Address: _____ Phone: _____

2. Name: _____ Address: _____ Phone: _____

HEALTH HISTORY (check and give approximate dates):

- | | | |
|---|--|--|
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Allergies _____ | Diseases: |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Chicken Pox _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Ivy Poisoning _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Insect Stings _____ | <input type="checkbox"/> German Measles _____ |
| <input type="checkbox"/> Behavior _____ | <input type="checkbox"/> Penicillin _____ | <input type="checkbox"/> Mumps _____ |
| | <input type="checkbox"/> Other Drugs _____ | <input type="checkbox"/> Rheumatic Fever _____ |

Operations or serious injuries (with dates): _____

Chronic or recurring illness: _____

Other diseases or details of above: _____

Any specific activities to be encouraged? _____

restricted? _____

IMPORTANT: Please notify the camp office at (781) 631-8081 if this person is exposed to any communicable disease during the three weeks prior to camp attendance.

Suggestions or additional comments from parent: _____

PARENT / GUARDIAN AUTHORIZATION:

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by me and the examining physician.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the child named above.

Signature: _____ Date: _____

IMMUNIZATION HISTORY:

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DTP Series: 4 doses rec'd: _____ Tetanus Booster: _____

Polio OPV (Sabin): _____

Measles Vaccine (live): _____ Tuberculin Test: _____

German Measles (Rubella): _____ Mumps Vaccine (live): _____

Hepatitis B: 3 doses rec'd – children born after 1/1/92: _____ Other: _____

Other state or municipal examinations required for staff (if any): _____

MEDICAL EXAMINATION – To be filled out by licensed physician:

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: S – Satisfactory
X – Not Satisfactory (Explain)
O – Not Examined

Height: _____ Weight: _____ B.P.: _____ Hgb. Test: _____ Urinalysis: _____

Eyes: _____ Extremities: _____

glasses: _____ Posture: _____

Ears: _____ Skin: _____

Nose: _____ Allergy: _____

Throat: _____ Please specify: _____

Teeth: _____

Heart: _____

Lungs: _____ General appraisal: _____

Abdomen: _____

Hernia: _____

For Girls and Women:

Has this person menstruated? Yes No

If not, has she been told about it? Yes No

If so, is her menstrual history normal? Yes No

Special considerations: _____

Recommendations and restrictions while in camp:

Special diet: _____

Special medicine (name): _____ Is parent sending it? Yes No (See Med Policy)

Swimming, diving: _____

Strenuous activity: _____

Other: _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically capable to engage in camp activities, except as noted above.

Signature of Examining Physician

Date

Phone

Print Name of Examining Physician

Address