Camp Gan Israel STAFF MEDICAL FORM 2025

Please email this form to bring or mail this form to the office at 79 Newtown Turnpike, Westport, CT 06880 at least 2 weeks prior to the start of camp.

Health Care Providers: Please review Section 1 of this form and then complete and sign Section 2 of this form.

Section 1: TO BE COMPLETED BY PATIENT

Complete this side of the Form, and attach a copy of the signed medical form listing the date of the last physical exam within 12 months of the start of camp you have along with a current immunization record signed by your doctor.

Name: _____ Date of Birth: _____ Weight: _____

Significant Health History (i.e., diabetes, seizures, heart disease, etc.) _____

_____

_____

Allergies (foods, drugs, plants, insects, etc.): _____

_____

Do you require an Epi-Pen: YES* _____ NO____ *If yes, complete *"Authorization for the Administration of Medication"* form.

Emotional Concerns (explain):_____

_____

Disability or chronic or recurring illness:

_____

_____

Anyspecificactivitiestobelimitedbyphysician'sadvice:Yes*_____No_____

*If yes, attach a letter of explanation.

Dietary modifications (if so, attach letter of explanation):

_____

Current medication(s)*

_____

Name of Dentist / Orthodontist: _____ Telephone No(s):_____

Please List Two Emergency Contacts:

1) Name _____ Relationship _____

Cell # _____ Work # _____ Home# _____

2) Name _____ Relationship _____

Cell # _____ Work # _____ Home #_____

SIGN HERE Signature _____ Date _____

EMERGENCY TREATMENT RELEASE: In the event, I give permission for the physician listed above to direct the treatment given to me. Should that physician not be available during a medical emergency, I give permission for the physician chosen by Camp Gan Israel to direct the treatment.

SIGN HERE Signature _____ Date _____

Section 2: TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

PHYSICAL EXAM DATE _____

Patient's Name:_____

Please attach an immunization record and complete this form.

Are immunizations up to date? YES or NO _____

Significant medical history (including seizures, surgeries, loss of consciousness, etc.):

_____

_____

Allergies (foods, drugs, plants, insects, etc.):

_____

Epi-pen needed? _____ Yes* _____ No

*If yes, please fill out and sign Section 3, Authorization for the Administration of Medication Form.

Emotional health concerns (ADD, ADHD, phobias, etc.):

_____

_____

Patient is under the care of a physician for the following condition (physical and / or behavioral):

_____

_____

Current treatment (include current medication):

_____

_____

Physical restrictions (please describe):

_____

_____

The above-mentioned patient has undergone a health evaluation within the past year and may fully participate in all Camp Gan Israel of Westport summer camp programs.

Date:_____(must be 2025)

Health Care Provider's Name:_____

Health Provider's

Signature:_____

TelephoneNumber:_____

If you would like to speak to someone in camp about this person, please call: 203.226.8584