Camp Shalom/ Noar- Bogrim Physician Form
****No child will be admitted to camp prior to receipt of this form****
*****There will be a $50 penalty for all forms received after June 1, 2018*****

It is the policy of the Jewish Federation of Madison that all children registered for Camp Shalom and Gan HaYeled certify on a form provided to the parents of the child following the child's registration that they are current on the vaccination schedule that is applicable to all children who seek to attend public schools in the State of Wisconsin. The only exception to this policy shall be for children whose parents present a statement from the child's physician certifying that for medical reasons the child cannot be vaccinated against a given disease or diseases.

The information contained in the health form is confidential. Information will be released only with the written permission of parent/guardian or to those working with the applicant.

THIS SIDE TO BE FILLED IN BY PARENT AND CHECKED WITH PHYSICIAN AT TIME OF EXAMINATION
PLEASE PRINT CLEARLY

CHILD'S FULL NAME_____ BIRTH DATE ___/___/___ GENDER _____

CHILD'S ADDRESS _____ CITY _____ STATE _____ ZIP_____

Health History/ Allergies (please include dates when possible)

☐ Ear Infections _____	☐ Seizure Disorders _____	☐ Hay Fever _____
☐ Rheumatic Fever _____	☐ Chicken Pox _____	☐ Poisin Ivy _____
☐ Convulsions _____	☐ Measles _____	☐ Penicillin _____
☐ Diabetes _____	☐ German Measles _____	☐ Other Drugs _____
☐ Behavior _____	☐ Mumps _____	
☐ Epilepsy _____	☐ Asthma _____	

Operations or serious injuries, please include dates:_____

Chronic or recurring illnesses:_____

Other diseases or details of above:_____

☐ Attached please find additional health information about my child and/or any medications he/she is currently taking.

IMPORTANT: PLEASE NOTIFY CAMP IF THIS CAMPER IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO CAMP ATTENDANCE.

NOTE: If your child needs to take any medications at camp, a separate release form must be filled out in advance. Please contact us if you need a form.

HEALTH/MEDICAL INSURANCE

Please Print

Name of health/ medical insurance carrier:_____

Policy or other identification number:_____

Name of primary physician:_____ Phone number:_____

Address of primary physician:_____

Preferred hospital:_____

PARENT AUTHORIZATION

This health history is correct and the person herein described has permission to engage in all prescribed 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 (at UW Hospital), secure proper treatment and to order injection, blood transfusion, anesthesia or surgery for my child as named above. I hereby certify that my child is covered by the health/medical insurance listed above and agree to notify Camp Shalom, in writing, should such insurance change.

_____Date_____

Parent/guardian's signature

(OVER)

PLEASE RETURN THIS FORM BY June 1, 2018 TO CAMP SHALOM, 6434 ENTERPRISE LANE, MADISON, WI 53719

CAMPER'S NAME_____ **DOB**_____

IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DtaP or DT)					
Polio					
Hib (Haemophilus *influenzae* Type B)					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had the chickenpox disease					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required.)

☐ No or Unsure (Vaccine is required)

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child WITHIN ONE YEAR.

☐ For health reasons this child should not receive the following immunizations: _____

Physician's Signature Required

☐ For religious reasons this child should not be immunized.

☐ For personal conviction reasons this child should not be immunized (please see Camp Shalom's policy regarding vaccinations above).

CAMPER INFORMATION

Date Examined _____

Height _____ Weight _____Blood Pressure _____

RECOMMENDATIONS AND RESTRICTIONS

The camper is under the care of a physician for the following condition(s):_____

_____

Current treatment (include medications):_____

_____

Any treatment to be continued at camp: _____

Any dietary restrictions:_____

Any allergies: _____

Additional health information: _____

Licensed Physician_____ **Signature** _____

Address _____ **Phone** _____

Date form completed _____ **Completed by** _____

Please use official medical seal/stamp as well. Thank you.