

### Camp Shalom/ Noar- Bogrim Physician Form

**\*\*No child will be admitted to camp prior to receipt of this form\*\***

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.

Please upload this form into your Active account or bring it with your camper on the first day of camp.

**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 \_\_\_\_\_

PARENT/GUARDIAN PRIMARY PHONE NUMBER \_\_\_\_\_

Health History/ Allergies (please include dates when possible)

<input type="checkbox"/> Ear Infections _____	<input type="checkbox"/> Seizure Disorders _____	<input type="checkbox"/> Hay Fever _____
<input type="checkbox"/> Rheumatic Fever _____	<input type="checkbox"/> Chicken Pox _____	<input type="checkbox"/> Poison Ivy _____
<input type="checkbox"/> Convulsions _____	<input type="checkbox"/> Measles _____	<input type="checkbox"/> Penicillin _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> German Measles _____	<input type="checkbox"/> Other Drugs _____
<input type="checkbox"/> Behavior _____	<input type="checkbox"/> Mumps _____	
<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> 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 \_\_\_\_\_

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.

Table with 6 columns: 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. Rows include Diphtheria-Tetanus-Pertussis, Polio, Hib, Measles-Mumps-Rubella, and Varicella.

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:
For religious or personal conviction reasons this child has not be immunized. (please see Camp Shalom's policy regarding vaccinations above):

Physician's Signature Required

Physician's Signature Required

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.