

MEDICAL EXAMINATION RECORD

Temple Akiba Resident Camp / Camp Akiba

A health exam is required for every camper. This examination is to be given and recorded by a California Licensed Medical Doctor. This form must be signed and dated. Examinations are good for six months if on prescription medications and have any medical conditions listed below or one-year for campers on no prescription medication.

Camper Name _____ Birthday _____ Age _____
(Last, first, & middle initial) (Month, day, & year)

Address _____ City _____ Zip _____
Father's Name _____ Phone (H) _____ (O) _____ (cell) _____
Address _____ City _____ Zip _____
Mother's Name _____ Phone (H) _____ (O) _____ (cell) _____
Address _____ City _____ Zip _____
Family Physician _____ Phone _____
Address _____ City _____ Zip _____
Emergency Contact _____ Phone _____ Relation _____
Address _____ City _____ Zip _____
Other/s _____

MEDICAL EXAM: To be completed and signed by a licensed physician.

Date of Examination: _____ **Allergies** _____

Code: s = satisfactory x = not satisfactory (explain) o = not examined

General Health and History _____
Blood Group/Type _____ Weight _____ Height _____
Blood Pressure _____ Pulse _____ Temperature _____ Hgb. Test _____; Urinalysis _____;
Eyes _____; Glasses /Contacts _____; Ears _____; Throat _____;
Nose _____; Mouth _____; Posture _____; Extremities _____; Skin _____;
Heart _____; Lungs _____ Asthma _____;
Kidneys/ Urinary Tract _____; Menstruation _____ (Is she prepared?) _____;
Bowels _____; Abdomen _____ (hernia)
Operations / Serious Illnesses _____
Special Considerations / Restrictions: _____
Medications/Equipment _____
Dietary Restrictions _____ Lactose Intolerant _____ Homesickness _____

Emotional Difficulties/Behavioral Disorders

The above info is very important. The more information we have, the better equipped we'll be to handle all situations that arise. Omissions or incomplete information could endanger the life of your camper or others...please be honest and forthcoming.

COPY OF FRONT AND BACK OF YOUR INSURANCE AND PRESCRIPTION CARD/S MUST BE ATTACHED TO THIS FORM

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Camper Name _____ **phone** _____

Immunization and Tests:

DTP _____ ORAL POLIO _____

MMR _____ TB Mantoux (last test) _____ Tetanus Booster _____

HEP B _____ CHICKEN POX _____ Other _____

Medications:

All Medication must have a Pharmacy Label with the Doctor's Prescription on it and accompanied by Written Instruction from Parent or Physician and to be taken under direction of Camp Nurse.

Please list all medications (including over the counter) taken routinely.

I hereby state that this child, with noted exception, is in apparent good health and is physically able to participate in strenuous activities at sea level and above 7,000 feet.

_____ **M.D.** _____

(Physician)

(Date)

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I/We, the undersigned parent(s) of _____, a minor, do hereby authorize **Rick Degelsmith**, Director of Camp Akiba, or the officers, leaders, or agents of Temple Akiba or Camp Akiba, as agents for the undersigned, to consent to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis, treatment and/or hospital care which is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the California Medical Practice Act, on the medical staff of a licensed hospital whether such examination, diagnosis, or treatment is rendered at the office of said physician or at such hospital. It is understood that this authorization is given in advance of any specific examination, diagnosis, treatment, or hospital care being required, and is given specific consent to any and all such examinations, diagnosis, treatment, or hospital care. I also certify that the aforementioned physician in the exercise of his best pursuant of the provisions of Section 25.8 of the Civil Code of California, has faithfully completed said examination determining that my child is physically fit in all regards to attend camp. This authorization shall remain effective for one year. I understand that incomplete, incorrect, or omission of important medical or emotional information could lead to my child being sent home from camp. We rely on your honesty to give us the information we need to deal with emotional issues that might not be evident to a doctor during examination. I give permission to the Camp Nurse to dispense over the counter medication(s) to my child :

One or Both Parents Must Sign this Form

DATE _____

(FATHER'S SIGNATURE)

(LEGAL GUARDIAN)

(MOTHER'S SIGNATURE)

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