This form must be returned by May 20 to:
CAMP YOFI
1 Federation Way, Suite 200
Irvine, CA 92603
FAX: 949-435-3401

Please print. Complete form in black or blue ink only.

PART I

Camper's Name____ □ Male □ Female
Address____
City________________________________State________Zip Code________________
Home Phone__________________________Email Address________________________
Age at camp________Date of Birth______________State camper was born in______________
Camper's Social Security Number____

PARENT INFORMATION

Mother/Custodial Parent________________ Father/Custodial Parent________________
Address________________________ Address________________________
City______________State__Zip code_____ City______________State__Zip code_____
Home Phone______________________ Home Phone______________________
Work Phone______________________ Work Phone______________________
Cell Phone______________________ Cell Phone______________________
Email__________________________ Email__________________________

If not available in an emergency, notify:
Name________________________________Relationship________________________
Phone Number 1________________________Phone Number 2______________________
Address____
City________________________________State________Zip Code________________

INSURANCE INFORMATION <u>(Must be completed and a copy of insurance card enclosed)</u>

Is the participant covered by family medical/hospital insurance? □ Yes □ No
If so, indicate carrier or plan name____
Group name__________________________Group Number________________________
Carrier address____________________________Phone Number__________________
Name of Policy Holder________________________Relationship to participant__________
Social Security Number of policy holder or insurance ID number__________________________

Physician Information

Name of family physician______________________Phone Number______________________
Address____
Name of family dentist/orthodontist______________Phone Number______________________
Address____

THIS SECTION MUST BE COMPLETE FOR ATTENDANCE

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer______________________________Date__________

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer______________________________________Date__________

HEALTH HISTORY

The following information must be filled in by the parent/guardian or adult camper/staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health care personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies

______________________________ ____
______________________________ ____
______________________________ ____

Food allergies

______________________________ ____
______________________________ ____
______________________________ ____

Other allergies Include insect stings, hay fever, asthma, animal dander, etc.

______________________________ ____
______________________________ ____
______________________________ ____

MEDICATIONS BEING TAKEN

Please list all medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging or bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

□ This person takes NO medications on a routine basis.

□ This person takes medications as follows:

Medication #1____

Dosage______________________________Specific times taken each day__________________

Reason for taking____

Medication #2____

Dosage______________________________Specific times taken each day__________________

Reason for taking____

Medication #3____

Dosage______________________________Specific times taken each day__________________

Reason for taking____

Medication #4____

Dosage______________________________Specific times taken each day__________________

Reason for taking____

Attach additional pages for additional medications.

Identify any medications taken during the school year that participant does/may not take during the summer:____

____

Reason for taking____

RESTRICTIONS

The following restrictions apply to____

Camper's Name

Dietary

□ Does not eat red meat □ Does not eat eggs □ Does not eat dairy products
□ Does not eat poultry □ Does not eat seafood
□ Other (describe)____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary):

____
____
____

General Questions (Please explain all "yes" answers below.)

Has/does the participant:	**Yes**	**No**
1. Had any recent injury, illness or infectious disease?	□	□
2. Have a chronic or recurring illness or condition?	□	□
3. Ever been hospitalized?	□	□
4. Ever had surgery?	□	□
5. Have frequent headaches?	□	□
6. Ever had a head injury?	□	□
7. Ever been knocked unconscious?	□	□
8. Wear glasses, contacts or protective eye wear?	□	□
9. Ever had frequent ear infections?	□	□
10. Ever passed out during or after exercise?	□	□
11. Ever been dizzy during or after exercise?	□	□
12. Ever had seizures?	□	□
13. Ever had chest pain during or after exercise?	□	□
14. Ever had high blood pressure?	□	□
15. Ever been diagnosed with a heart murmur?	□	□
16. Ever had back problems?	□	□
17. Ever had problems with joints? (e.g., knees, ankles)	□	□
18. Have an orthodontic appliance being brought to camp?	□	□
19. Have any skin problems? (e.g., itching, rash, acne)	□	□
20. Have diabetes?	□	□
21. Have asthma?	□	□
22. Had mononucleosis in the past 12 months?	□	□
23. Had problems with diarrhea or constipation?	□	□
24. Have problems with sleepwalking?	□	□
25. If female, have an abnormal menstrual history?	□	□
26. Have a history of bedwetting?	□	□
27. Ever had an eating disorder?	□	□
28. Ever had emotional difficulties for which professional help was sought?	□	□
29. Does camper wear braces?	□	□
30. Can minimal orthodontic work be done?	□	□

Please explain any "yes" answers, noting the number of the question.

____
____
____

Parent/Guardian Authorizations:

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

Signed__________________________Printed__________________________Date________________

PART II
DOCTOR'S FORM

Licensed Medical Personnel must complete the following:
Camper's Name____

Which of the following has the participant had?
□ Measles □ Chicken Pox □ German Measles □ Mumps □ Hepatitis

TB Mantoux Test
Date of last test______________________ Result: □ Positive □ Negative

Please give all dates of immunization.

Vaccine:	Dates: Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DTP	______	______	______	______	______
TD (Tetanus/Diphtheria)	______	______	______	______	______
Tetanus	______	______	______	______	______
Polio	______	______	______	______	______
MMR	______	______	______	______	______
Or Measles	______	______	______	______	______
Or Mumps	______	______	______	______	______
Or Rubella	______	______	______	______	______
Haemophilus influenza B	______	______	______	______	______
Hepatitis B	______	______	______	______	______
Varicella (chicken pox)	______	______	______	______	______
BCG	______	______	______	______	______

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.

____
____
____
____
____
____

Return this form by May 20 to:

Merage JCC/CAMP YOFI
1 Federation Way, Suite 200, Irvine, CA 92603
FAX: 949-435-3401

Health Care Recommendations by Licensed Medical Personnel
Physical examination must be done after September 2006 to be current.
If last exam was before September 2006, do not complete until participant has a new exam.

Camper's Name_______________________Date of last examination_______________________

BP______________________ Weight__________________ Height____________

In my opinion, the above applicant ____ is _____is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

____

____

Current treatment at the time of this report includes:

____

____

Recommendations and Restrictions at camp
Treatment to be continued at camp

____

____

Medications to be administered at camp (name, dosage, frequency)

____

____

Any medically-prescribed meal plan or dietary restrictions

____

____

Known allergies

____

____

Description of any limitation or restriction on camp activities

____

____

Additional information for health care staff at the camp

____

____

____

Signature of Licensed Medical Personnel____

Printed____Title___________________________

Address____

Phone____Date___________________________

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