

MEDICAL CERTIFICATE
Chabad Kiddie Camp
DAY CAMP 2010 — 5770
 201-907-0686
 201-907-0668 Fax

Camper's Name _____ Date of Birth _____
 Parent's Name _____
 Insurance Carrier _____
 Holder's Name _____
 Group Name and Number _____
 ID Number _____

Immunization History (Please attach a copy of your child's immunization record)

Diphtheria _____ Hepatitis A _____
 Tetanus _____ Hepatitis B _____
 Polio _____ HIB _____
 Measles _____ Influenza _____
 Pertussis _____ Pneumococcal _____
 Mumps _____ Varicella _____
 Rubella _____

Medical History _____ Date _____
 Is/has you child being/been treated for the following:
 Diabetes ____ Seizures ____ Frequent Headaches ____
 Hay Fever ____ Rheumatic Fever ____
 Asthma ____ Frequent Strep ____ Dizziness ____
 Frequent Ear Infections ____ Frequent stomach aches ____

**FOR ALL ALLERGIES PLEASE ATTACH
 EMERGENCY HEALTH CARE PLANS**

<u>Allergies</u>	Yes	No	Comments
Penicillin			
Sulfa			
Aspirin			
Other Drugs			
FOODS**			

Current Medications		

Name	Dosage	Reason
Other Medical Information:		

Restrictions:		
Diet _____		
Swimming _____		
Other _____		

Authorization to Consent to Treatment of Minor Temporarily Separate from Parents:

I, the parent(s) or guardian(s) of _____, authorize the director of Chabad Kiddie Camp, the Camp Nurse, and/or Rabbi Ephraim Simon as our agents to consent to any diagnostic procedure or medical care, which is deemed advisable by any licensed physician during the camp session of the summer of 2009. I also authorize the release of pertinent medical information (medical conditions, allergies and/or medical treatments) to be exchanged among appropriate staff/counselors involved with my child, in a private and confidential manner.

Parent's signature _____ Date _____

Please include copy of insurance card. Copy attached