MEDICAL CERTIFICATE

Chabad Kiddie Camp

DAY CAMP 2019 — 5779

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

Allergies	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 2017. 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