CHAIM DAY CAMP
1310 AVENUE I, BROOKLYN, NY 11230

מתיבתא ישיבה רבנו חיים ברלין
MESIVTA YESHIVA RABBI CHAIM BERLIN
SUMMER ACTIVITIES PROGRAM

WHERE SUMMER COMES TO LIFE

Rabbi Meir Leib Yanofsky, Director

HEALTH RECORD FOR CHILDREN IN SUMMER PROGRAMS

(This side to be filled in by parent before presentation to physician)

_____ _____ __/__/__ Sex ❑M ❑F
Child's Last Name Child's First Name Date of Birth

Home Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Place of Employment: Father _____ Phone: _____ Cell: _____

Mother _____ Phone: _____ Cell: _____

In case of emergency, if parent or guardian is not available, please notify:

1. _____ Phone: _____ Cell: _____

2. _____ Phone: _____ Cell: _____

HEALTH HISTORY:

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance: ❑Yes ❑No If yes, state type of exposure_____

Diseases

❑ Asthma
❑ Chicken Pox
❑ Convulsion
❑ Diabetes
❑ Ear Infection
❑ Measles
❑ Medication taking _____
❑ Rhuematic Fever
❑ Other past illnesses_____
❑ Operation or serious injuries __/__/__
❑ Hospitalization __/__/__ __/__/__
❑ Chronic or recurring illness_____
❑ Mumps

Allergies

❑ Hay Fever
❑ Insect Stings
❑ Penicillin
❑ Poison Ivy etc.
❑ Other Drugs_____
❑ Food _____

Any condition that require activities to be restricted_____

Permission for all program activities unless otherwise noted by doctor_____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to Chaim Day Camp staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Signature _____ Relationship _____ Date _____

Telephone: 718-377-5800 *Fax: 718-709-7037* *Email:chaimdaycamp@myrcb.org*

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Tel 718-377-5800 Fax 718-709-7037 Email chaimdaycamp@myrcb.org

PHYSICAL EXAMINATION

(To be filled out by Physician)

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the needs of this child in the summer program. (Examination is acceptable when performed no more than 12 months prior to arrival at camp.)

IMMUNIZATION HISTORY

DPT/DTaP or DT OR TD	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
IPV/OPV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
POLIO	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
HEPATITIS B	__/__/__	__/__/__	__/__/__		
HIB	__/__/__	__/__/__	__/__/__		
MMR	__/__/__	__/__/__			
VZV	__/__/__	__/__/__			

Other_____

MEDICAL EXAMINATION

General Appearance _____	Height ___ ft. ___ in.	Weight _____ lbs.	Blood Pressure _____
Hgb. Test _____	Urinalysis_____	Genitalia _____	Neurological Findings _____
Throat-Tonsils _____	Eyes _____	Vision _____	Glasses _____
Ears _____	Hearing _____	Extremities _____	Heart _____
Feet _____	Lungs _____	Skin _____	Nose _____
Teeth _____	Abdomen_____	Hernia _____	Posture & Spine _____

❑ Allergy (Please specify)_____

Describe abnormal findings and/or handicapping conditions_____

Recommendations and restrictions while in camp:

❑ Special diet: _____ ❑ Special medicine _____

Any restrictions to ❑ Activities_____ ❑Swimming_____ ❑Diving_____

I have examined the person herein described, reviewed his health history and it is my opinion that he is physically able to engage in Day Camp/Youth Program activities, except as noted above.

_____ _____ __/__/__ Date of examination __/__/__
Name of Physician Signature of Physician Date

Telephone _____ Address _____