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CAMP GAN ISRAEL OF ORLANDO

Please complete the entire form and print neatly.

Name of Camper _____ Boy ___ Girl ___ Age ___
last first

Week of camp attending: ___ 1st ___ 2nd ___ 3rd ___ 4th Late Stay _____

Previous camp experience _____

Does your child swim? Yes ___ No ___ Does child have fear of water? Yes ___ No ___

Swim Level: List most recent American Red Cross Card child earned, date and place:

Name of public/private school now attending _____

Name of synagogue affiliated with _____

Jewish Education: Type of program (after school, day school, nursery or Sunday school),

Years attended _____

Please list brothers and sisters:

Name _____ Age ___ Name _____ Age ___ Name _____ Age ___

Father's Jewish Name _____ Mother's Jewish Name _____

Any information or comment about special talents, habits, behavior or other:

T- Shirt Size _____ Amount _____ @ \$6 each. (added to tuition)

Please list 2 emergency contacts:

Name _____ Phone _____

Name _____ Phone _____



For Office Use

Dates of Camp Attendance _____

Health History Form for Children, Youth and Adults Attending Camps

Developed and approved by the **American Camping Association®** with the American Academy of Pediatrics.

Mail this form to the address below by May 30 - (April 10 for early bird special)
PO Box 690282
Orlando, FL 32869-0282 or fax to: 1877.835.6090

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form

to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Year

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social Security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) Street address City State Zip

Business address _____
Street address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business Address _____ Phone _____
Street address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

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Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No
If so, indicate carrier or plan name _____ Group # _____

▶ **Photocopy of front and back of health insurance card must be attached to this form.**

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.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral billing, or

insurance purposes. I give permission to the camp to 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 to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photo-copied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____
Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.
Signature of minor or adult camper/staffer _____ Date _____

Important - These boxes must be complete for attendance*

ALLERGIES List all known. Describe reaction and management of the reaction.
Medication allergies (list) _____

Food allergies (list) _____

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

Name

