



CAMP GAN ISRAEL

CELEBRATING OVER 50 YEARS

MEDICAL EXAMINATION REPORT

Name of Camper: _____ Date of Birth: / / _____

Address: _____ Telephone No.: _____

Name of Doctor: _____ Telephone No.: _____

Health Ins. No. (*Quebec Only*): _____ Expiration Date : : / / _____

In case of emergency please call: _____ Telephone No.: _____

1. Has the camper ever had any serious disease? NO YES
Please list: _____
 2. Has the camper ever had any operation? NO YES
Please list: _____
 3. List all allergies To Medication: _____
Other _____
 4. List all medicines being taken - Optional: _____ Necessary _____
 5. Date of last Tetanus booster: ____/____/____
 6. Has there been any significant illness within the past 12 months? NO YES
Describe: _____
 7. Has there been any contact with Hepatitis or any other communicable disease in the last 3 months? NO YES List: _____
 8. Has any Vaccine been given? NO YES
Which _____ Date ____/____/____
 9. Are there any restrictions in:
Swimming: NO YES | Hiking: NO YES | Sports: NO YES
Physical Condition: Height: _____ Weight: _____ In Satisfactory health? NO YES
Problem? _____
- Signature of examining doctor: _____

If it is necessary, in the judgment of the Administration, to use outside medical, surgical or dental aid for the health and well-being of the camper, I hereby authorize the Camp Administration to use such outside medical aid, for which I will reimburse Camp.

Signature of Parent: _____ **Date:** / / _____