



Camp Desert Star
Jewish Community Center of the Desert
WOW - With Out Walls
69-930 Hwy III, Suite 204
Rancho Mirage, CA 92270
760-324-4737

CAMPER HEALTH FORM

PLEASE NOTE: ONE FORM PER CHILD MUST BE SUBMITTED TO THE CAMP BEFORE THE FIRST DAY OF CAMP. NO CHILD WILL BE ALLOWED TO ATTEND WITHOUT THIS FORM ON FILE.

Child's Name _____ Birthdate _____ Age at Camp _____
Last First Middle

Address _____
Street Address City State Zip Phone

Social Security Number of Camper _____ Gender: [] Male [] Female

Custodial Parent/Guardian _____ Phone _____

Home Address _____
(if different) Street Address City State Zip Cell/Pager

Business Address _____
Street Address City State Zip

Second Parent or Guardian or Emergency Contact _____ Phone _____

Address _____
Street Address City State Zip Cell/Pager

If not available in an emergency, notify _____

Relationship _____ Phone _____ Cell/Pager _____

Address _____
Street Address City State Zip

INSURANCE INFORMATION

Family Medical Insurance Carrier _____ Policy Holder's Name _____

Policy/Group # _____ ID # _____

➔ **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 insurance purposes. I give permission to the camp to arrange necessary related transportations for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician/nurse selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian _____ Date _____

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication Allergies

Food Allergies

Other Allergies (insect stings, hay fever, asthma, animals, etc.)

MEDICATIONS BEING TAKEN AT CAMP

Please list ALL medications (including over-the-counter and prescription) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

[] This person **takes NO medications** on a routinely basis. **OR** [] This person **takes medications** as follows.

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Identify any medications taken during the school year that participant does/may not take during the summer.

RESTRICTIONS

Dietary _____

Activity Restrictions & Limitations _____

GENERAL QUESTIONS (Explain "yes" answers on a separate sheet of paper)

Has/does the participant:	Yes	No		Yes	No
1. Any recent injury of illness?	[]	[]	16. Ever had back problems?	[]	[]
2. Have a chronic or reoccurring illness/condition?	[]	[]	17. Ever had problems with knees or ankles?	[]	[]
3. Ever been hospitalized?	[]	[]	18. Ever had an orthodontic appliance being brought to camp?	[]	[]
4. Ever had surgery?	[]	[]	19. Had any skin problems? (itching, rash, etc.)	[]	[]
5. Have frequent headaches?	[]	[]	20. Have diabetes?	[]	[]
6. Ever had a head injury?	[]	[]	21. Have asthma?	[]	[]
7. Wear glasses, contacts, or protective eyewear?	[]	[]	22. Had mononucleosis in the past 12 months?	[]	[]
8. Ever been knocked unconscious?	[]	[]	23. Had problems with diarrhea/constipation?	[]	[]
9. Ever had frequent ear infections?	[]	[]	24. Have problems with sleepwalking?	[]	[]
10. Ever passed out during or after exercise?	[]	[]	25. If female, have an abnormal menstrual history?	[]	[]
11. Ever been dizzy during or after exercise?	[]	[]	26. Have a history of bed-wetting?	[]	[]
12. Ever had seizures?	[]	[]	27. Ever had an eating disorder?	[]	[]
13. Ever had chest pain during or after exercise?	[]	[]	28. Ever had emotional or behavioral difficulties for which professional help was sought?	[]	[]
14. Ever had high blood pressure?	[]	[]			
15. Ever been diagnosed with a heart murmur?	[]	[]			

Which of the following has the participant had:

[] Measles [] Chicken Pox [] German Measles [] Mumps [] Hepatitis A [] Hepatitis B [] Hepatitis C

Please attach a copy of the participant's dates of immunizations. ALL IMMUNIZATIONS MUST BE UP TO DATE OR YOUR CHILD MAY NOT BE ADMITTED TO CAMP. (from your doctor's office)

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____