B"H

MEDICAL PERMISSION REQUEST FORM

ETHEL & IRVING
BERKOWITZ
GAN ISRAEL
DAY CAMP

Camper's Name _____

Height _____ Weight _____ Blood Pressure _____

Pulse _____ Vision *Right* _____ *Left* _____

Glasses or other appliances _____

IMMUNIZATION HISTORY

DPaP, DTP or TD:	Date_____	Date_____	Date_____	Date _____
Polio	Date_____	Date_____	Date_____	Date _____
MMR	Date_____	Date_____	Date_____	Date _____
HIB	Date_____	Date_____	Date_____	Date _____
Hepatitis B	Date_____	Date_____	Date_____	Date _____
Varicella	Date_____	Date_____	Date_____	Date _____
Other	_____			

EXAM	NORMAL	ABNORMAL	DESCRIPTION
Eyes			
Ears			
Nose & Throat			
Neck			
Heart			
Lungs			
Abdomen			
Genitals			
Skin			
Extremities			
Spine			
Neurological			
Other			

Operations/Previous Illness _____

Medications _____

Allergies _____

Special Conditions _____

On the basis of my medical examination and the child's past history, it is my opinion, the above child

☐ May ☐ May not participate in all activities

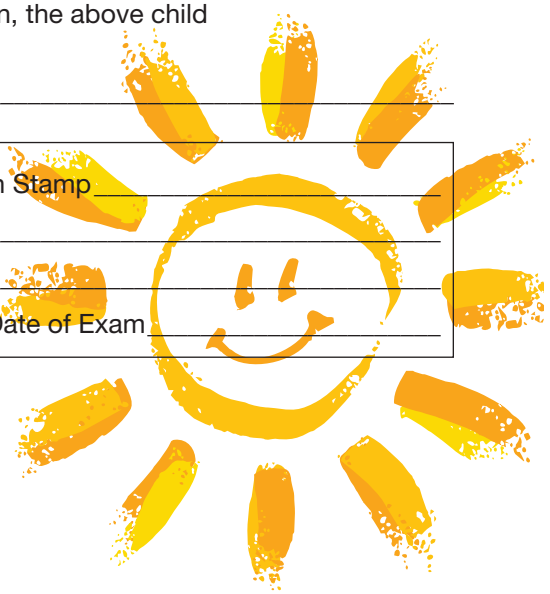
Limitations _____

Physician's Signature _____ Physician Stamp _____

Physician's Name _____

Address _____

Phone _____ Date of Exam _____



Please mail or email this form to:

A Program of Chabad of Port Washington
80 Shore Road • Port Washington, NY 11050
P 516 767 TORAH • chabadpw.org

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DAY CAMP

In accordance with the Nassau County Department of Health any camper needing medication during camp hours must do the following:

1. Present a written consent form signed by a parent or legal guardian
2. Bring the medication in the original prescription bottle, properly labeled by a registered pharmicist as prescribed by law
3. Submit this completed medication permission from the prescribing physician

TO BE COMPLETED BY PARENT

Name of Camper _____ Date of Birth _____

Name of Camp BERKOWITZ GAN ISRAEL DAY CAMP

I, _____ , give permission for my child to receive the medication(s) specified below as directed.

Parent/Guardian Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN

MEDICATION	DOSAGE PER PILL (MG)	NUMBER OF PILLS PER DOSAGE	TOTAL DOSAGE	TIMES – AM / PM

Are there any restrictions? ☐ Yes ☐ No

If yes, what and how long? _____

_____

The following side effects should be reported to me _____

_____

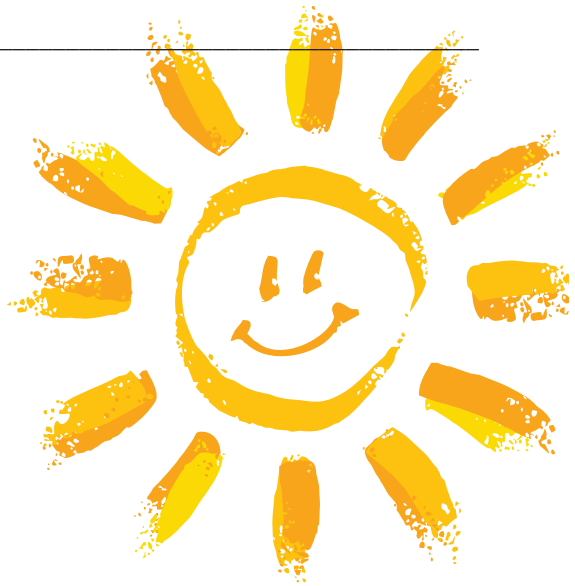
_____

Physician's Signature _____

Physician's Name Printed _____

Physician's Phone _____

Date _____



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