

ENCAMPMENT '15 MEDICAL FORMS

These forms should be EMAILED back to us, or uploaded into REGPACK:

_____ **PHYSICAL EXAM FORM**

_____ **USY/KADIMA Medication Form (If you are bringing ANY medications to camp)**

**All paperwork is to be either UPLOADED into REGPACK or
SCANNED IN and emailed to:**

Tzafonecamp15@gmail.com

Or

epa.hagesherecamp15@gmail.com

(Please send to the email based on your home region)

Or uploaded to your specific region REGPACK account.

Questions or for more information,
USYers/Kadimaniks from TZAFON: please call SANDRA GOLDMEER, Regional Youth Director,
at 518-859-1241, or email: goldmeer@uscj.org

USYers/Kadimaniks from EPA or Hagesher: please call RENEE STRAUSBERG, Regional Youth Director,
at 215-870-7902, or email: strausberg@uscj.org

PHYSICAL EXAMINATION FORM

To be filled out by licensed physician.

NAME OF CHILD: _____

INSTRUCTIONS

DEADLINE FOR HEALTH FORM – AUGUST 1, 2015

NOTE: This is REQUIRED for ALL PARTICIPANTS
The date of examination must be have been in the last
12 months (Since August 1, 2014).

DATE OF EXAMINATION: _____

Please record the date (month and year) of basic immunization and most recent booster doses:

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus	3	
Or		
Tetanus		
Diphtheria		
Or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		

Health Examination by Licensed Physician

Code: √ -- Satisfactory x – Not Satisfactory (explain)

Hgt. _____ B.P. _____ Urinalysis test done _____ Wt. _____ Hgb. Test done _____
 Eyes _____ Extremities _____ Glasses _____ Posture (Spine) _____ Ears _____
 Skin _____ Nose _____ Allergies (please specify) _____

Teeth _____ Heart _____ Menstrual history _____ Lungs _____ Abdomen _____
 Throat _____ Genitalia _____ Hernia _____ General appraisal _____

I have examined the above camp applicant on (date) _____
 In my opinion, the above condition does _____/does not _____ preclude his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s): _____

Current treatment (include current medication): _____

Is child recovering from addiction, eating disorders or psychological conditions? _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? Yes ___ No ___ Does applicant have diabetes? Yes ___ No ___

Recommendations and Restrictions While at Camp (diet, medicine, treatment, etc.) _____

Additional Health Information _____

Licensed Physician's Signature** _____ Phone (_____) _____

Print physician's full name: _____

Full Address _____ *Initial if completed by nurse or physician's assistant.

Parents –

Following is our **ENCAMPMENT MEDICATION FORM** for the upcoming encampment. If it will be necessary for your child to take any medication, included but not limited to, prescription, over the counter or any other dietary or health supplement, please make sure to carefully complete and return this form (by either uploading it to Regpack along with the physician form or Emailing it to the one of the email addresses below) before Encampment.

No medication will be dispensed unless we have written instructions.

In past years, we have had instances of improperly labeled medications. For the safety of your child and all other participants, the following will be strictly adhered to:

- All medications will be collected upon arrival, outside of Epi-pens and Inhalers.
- All medications will be dispensed or administered by the medical staff. The usual times will be at meals, unless there is absolute need for other times, which are indicated on the form.

To be accepted in camp, each medication must be in its **Original Container**. In addition, **all prescription medications must have:**

- The original prescription label
- The names of your child and doctor, date of prescription, directions and medication name.
- One medication per container. Please make sure they are in the correct container.

All medications not prescribed, or not absolutely necessary, should not be sent to camp. The infirmary is stocked with all standard over the counter medications (i.e., Tylenol, Sudafed, cough syrup, PeptoBismol, Mylanta, etc.) **When sending medications to camp, please send them in one large Ziploc bag with your child's name on it in Tape and separated by daily medications and "as needed" medications.**

If your child's medical history or medication needs change before Encampment, **please call us prior to Encampment** to update their files, as well as sending us a note with your child to confirm these changes. While we realize changes may occur even the day before, we need this information to correctly care for your child.

Please list all medications on the Medication form and return, along with the Physician form, to:

Tzafoncamp15@gmail.com

Or

epa.hagesherecamp15@gmail.com

Please use whichever email applies to your specific region.

NOTE: FAILURE TO FOLLOW THESE INSTRUCTIONS MAY MEAN THAT A PARTICULAR MEDICATION MAY NOT BE DISPENSED OR ADMINISTERED.

Tri Regional Encampment Kadima / USY MEDICATION FORM

This form authorizes USCJ staff to hold and to provide the participant with his/her prescription medication as required.

USYer/Kadimanik's Name _____ Date of Birth _____

Height _____ Weight _____ Gender Male ___ Female ___

Drug Allergies _____

	MEDICATION NAME	DOSE IN MILLIGRAMS/ & # OF PILLS	TH	FRI	SAT	SUN	MON	TU
BREAKFAST								
LUNCH								
DINNER								
BED TIME								
"AS NEEDED" MEDICATION JUST LIST								

I hereby notify USY/Kadima that I am (my child is) capable of self-administering the following medication/medical treatment, and I authorize USY/Kadima to allow me (my child) to self-administer:

EPI PEN
 INHALER
 TOPICAL CREAM
 NASAL SPRAY

My child and I understand and agree to follow the instructions set forth in the letter that accompanied this form.

Signature of Parent or Guardian

Date

PLEASE NOTE – USY AND KADIMA MUST KNOW IN ADVANCE OF ANY CHANGES IN MEDICATION.