



Please Check: Lishma
 Staff
 Meytiv

ADULT MEDICAL FORM

(18 years of age and over)

Name _____ Birth Date _____ Male Female
Last First Middle

Home Address _____
Street Address City State Zip

Home Phone () _____ Social Security Number _____

Emergency Contact _____ Relationship _____

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

GENERAL QUESTIONS (Explain "yes" answers below.)

Do/Have you:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Ever used tobacco, have an addiction, or substance abuse history?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions (attach additional pages as needed)

Which of the following have you had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis

Please give date for last immunization for:

Date	Vaccine
_____	Tetanus
_____	Hepatitis B
_____	MMR (measles, mumps, rubella)
_____	Last TB test
	Result
	Other _____

Allergies: Please list all known allergies (including medication, food, etc.). Describe reaction and management of the reaction

Current Medications: _____

Use this space to provide any additional information about your physical, emotional, or mental health about which the camp should be aware, including restrictions to activity, (adaptations, limitations, etc.) _____

Name of family physician _____ Phone () _____

Address _____

Name of family dentist/orthodontist _____ Phone () _____

Address _____

I declare that this health history I have provided is correct and complete.

Signature: _____ Print Name: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

I have examined the above camp participant. Date of last examination _____

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions _____

Current treatment at the time of this report includes _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Any medically-prescribed meal plan or dietary restrictions _____

Additional information for health care staff at the camp _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) 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 routine 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 _____

Attach additional pages for more medications.

Signature of Licensed Medical Personnel

Printed _____ Title _____

Address _____

Phone () _____ Date ____/____/____ Signature _____

Insurance Information (Please enclose a copy of front and back of your insurance card)

Are you covered by medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social Security number of policy holder or insurance ID number _____

TO BE COMPLETED
BY PARTICIPANT

Screening Record

Date screened _____ Time _____ am pm

Meds received _____

Updates/additions to health history noted Yes No None required

Current health needs identified _____

Observational notes _____

Screened by _____

FOR CAMP USE ONLY

THIS FORM MUST BE RETURNED TO THE RAMAH OFFICE NO LATER THAN MAY 1ST