



CAMP RAMAH IN CALIFORNIA, INC. (805) 646-4301

EMERGENCY MEDICAL CARD

MUST BE COMPLETED BY A PARENT/GUARDIAN. PLEASE TYPE OR PRINT CLEARLY WITH A PEN.

1st Session

2nd Session

Gesher A B C D

Staff (under 18)

Gan Child

CAMPER INFORMATION

Camper's Name: (last, first)		Sex: M F	Camper's Social Security #		
Address: St. No. & Name		City	ST	Zip	Cell/pager #: ()
Date of Birth: Mo/Day/Yr		Grade in School: (as of Fall after camp)		Age (Yrs/Mos): (as of Fall after camp)	
			Home phone ()		

PARENT'S AGREEMENT, MEDICAL AUTHORIZATION, AND HEALTH INSURANCE INFORMATION

Please read carefully and sign below

*In case of emergency, I hereby give permission to the Camp Director or his representative to authorize the administration of health care service to my child by a physician or other professional health care provider (hospital, paramedic, nurse, etc.). I also give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child. I understand that Camp Ramah assumes no responsibility for the payment, adequacy or quality of service rendered by the physician or other health care providers selected in such an emergency. I also give my permission to the physician or camp personnel selected by the Director to advise or treat my child for any illnesses or medical condition while he or she is at camp. *This completed form may be photocopied for trips out of camp.*

Liability limits of Camp Ramah's insurance: In case of illness or accident, all claims must be filed initially with your individual insurance carrier. The camp's insurance may cover deductibles and other amounts not covered by your private insurance carrier up to a limit of \$1,000. In the absence of insurance coverage, I (the parent/guardian) accept responsibility for all medical costs. I accept all responsibility for costs of medications prescribed, dental and orthodontic treatments. I authorize the camp to deal directly with my health insurance as stated below:

Name of Insurance Co.: _____ Policy # _____

Address of Insurance Co.: _____ Phone # _____

Employer's Name: _____ Subscriber's Name _____

Signature: _____ Date: _____

PARENT CONTACT INFORMATION

Child lives primarily with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	Name of Legal Guardian:
Father Name: (last, first) Mr. Dr. Rabbi	Mother Name: (last, first) Mrs. Ms. Dr. Rabbi
Bus. Phone: () Fax: () Cell: () Pager: ()	Bus. Phone: () Fax: () Cell: () Pager: ()

EMERGENCY CONTACT INFORMATION (Person to contact in case of emergency other than parent)

Name:	Relationship to Camper:
Home: () Fax: () Work : ()	Cell: () Pager: ()

HEALTH HISTORY (To be completed by parent)

MEDICATIONS BEING TAKEN Please list all medications (prescription and non-prescription) that your child takes on a routine basis.

Medication	Dosage	Specific Times Taken Daily	Reason For Taking

Has participant been hospitalized? When? For what reason?

Check any of the following which the participant has/had?

- | | | | | |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Insect Bite Allergy | <input type="checkbox"/> Psychotherapy/Counseling | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Seizures | <input type="checkbox"/> T.B |
| <input type="checkbox"/> Ear Infections (frequent) | <input type="checkbox"/> Injuries | <input type="checkbox"/> Poison Oak Allergy | <input type="checkbox"/> other _____ | |

Please explain any items checked:

- Allergy to other medication. Please specify _____ What is Reaction? _____
- Food Allergies - Which Foods? _____

Name of Camper's Regular Physician	Office Phone Number ()
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